CREDENTIALING APPLICATION

Please submit completed applications and all required documents to:

ccnvintake@ccnva.com
OR
3831 Westerre Parkway, Suite 1
Henrico, VA
23233

APPLICANT'S NAME: _____

The following services are requested for this provider (check one):

- ☐ Primary Source Verification (PSV)
- ☐ Provider Enrollment (PE)
- ☐ Primary Source Verification and Provider Enrollment (PSV/PE)

If this application is not complete on submission, and a completed application is not submitted within one hundred and twenty (120) days, the application WILL be returned as incomplete and all associated fees WILL be invoiced. The client will have to pay the application fees a second time when the application is resubmitted.

CCNV will enroll this provider in plans that accept this provider type and specialty per client request.

CHECKLIST FOR APPLICATION SUBMISSION

All sections of this application **MUST** be completed. Any incomplete sections will be returned for correction, and any required documents (below) must be received before credentialing can be completed. Please be aware that incomplete applications will delay credentials verification and health plan enrollment.

Please also note that lack of board certification or DEA certification may delay and/or prevent health plan enrollment with some health plans, depending on requirements.

The documents listed below are REQUIRED and credentialing cannot be completed until they are received.

- ☐ Current CV in **month/year** format, listing education/training and work history. All education and training must include start and end dates, also in month/year format. Any gaps greater than six months **must** have an attached explanation. Must include addresses for all previous work locations where possible.
- ☐ Copies of current **active** and **unrestricted** license(s) for each state in which you practice.
- ☐ Copy of current DEA/CDS certificate(s). The address on the DEA certification must reflect the **current** primary work location. **Note:** applicants who do not prescribe controlled medications are waived from this requirement.
- ☐ If DEA/CDS certification is pending/not listed to the current work address, a letter from your organization describing the admitting arrangements until DEA/CDS certification is active, is required.
- ☐ Copy of ECFMG certificate, if applicable.
- ☐ Copy of diploma of highest degree received.
- ☐ Copy of resident training certificates, as applicable.
- ☐ MD's and DO's without hospital privileges must submit letter describing organization's admitting arrangements. Letter must include the name of the practitioner who will do the admitting, and the name of the hospital. If hospitalist on call is indicated, CCNV can accept.
- ☐ Copy of board certification certificate(s), as applicable.
- ☐ If not board certified, must submit at least sixty (60) continuing medical education (CME) certificates from the last two (2) years. **Note:** not applicable to recent graduates.
- ☐ Copies of malpractice certificates demonstrating at least five years of coverage.
- ☐ Copy of current malpractice insurance. The certificate must include initial date, expiration date, and malpractice limits.
- ☐ Copy of any state or federal photo ID.
- ☐ Completed and signed "Attestation and Explanation" form. *(Included in this packet.)*
- ☐ Completed and signed "Authorization and Release" form. *(Included in this packet.)*
- ☐ Employment letter on company letterhead that includes the practitioner's name and start date, and is signed by an authorized employee of the company. *(Dental practitioners only.)*

The documents listed below are required for enrollment, which cannot be completed until they are received.

- ☐ Completed and signed "CAQH Release" form. ORIGINAL SIGNATURE ONLY. *(Included in this packet.)*
- ☐ Completed and signed "Enrollment Packet." Forms available are Medical, Dental, or Behavioral Health.

1. Personal Information

Practitioner Name: _____
Last First Middle

Professional Degree (MD, DO, DDS, DMD, DPM, NP, PA, MSN, PSY.D., etc.): _____

Prior Names, including maiden and previous married: _____

Home address: _____
Street City State Zip

Email address: _____ Social Security Number: _____

Personal Phone Number: _____ Date of Birth: _____ Gender: _____

Citizen of Country: _____ Are you eligible to work in the United States? Yes ☐ No ☐

Place of Birth: _____ Date of Hire: _____

Do you speak/write English fluently? Yes ☐ No ☐ List any other languages spoken: _____

Are you a PCP? Yes ☐ No ☐ Practice limitations or restrictions? Yes ☐ No ☐ If yes: _____

2. Practice Information

Primary Practice Location:

DBA ("Doing Business As") Name of Organization: _____

Practice Site Name: _____

Address: _____
Street City State Zip

Phone: _____ Fax: _____ Is this location ADA compliant? Yes ☐ No ☐

Office Contact Name: _____ Office Contact Email: _____

Are you accepting new patients at this location? Yes ☐ No ☐ What is your start date at this location? _____

Employment status at this location (FT/PT/Locum/Volunteer): _____

Practitioners who provide coverage in your absence: _____

Hours worked at this location:

Monday: _____ to _____. Tuesday: _____ to _____. Wednesday: _____ to _____. Thursday: _____ to _____.

Friday: _____ to _____. Saturday: _____ to _____. Sunday: _____ to _____.

Additional Practice Location:

Secondary Practice Site Name: _____

Secondary Practice Address: _____
Street City State Zip

Phone: _____ Fax: _____ Is this location ADA compliant? Yes ☐ No ☐

Are you accepting new patients at this location? Yes ☐ No ☐ What is your start date at this location? _____

Employment status at this location (FT/PT/Locum/Volunteer): _____

If you have more than one additional site location, please attach a separate document with all additional addresses.

Billing/Pay To Location:

Corporate Name (as it appears on W-9): _____

Billing/Pay To Address: _____
Street City State Zip

Billing/Pay To Phone: _____ Billing/Pay To Fax: _____

3. Licenses and Certification

Attach copies of all listed below. If you have more than two state license, please attach extra pages when submitting application.

1) State License #: _____ Issuing State: _____ License Type (MD, NP, RN, etc): _____

Date Issued: _____ Expiration Date: _____ License Status (active, expired, etc) _____

2) State License #: _____ Issuing State: _____ License Type (MD, NP, RN, etc): _____

Date Issued: _____ Expiration Date: _____ License Status (active, expired, etc) _____

3) CDS License #: _____ Date Issued: _____ Expiration Date: _____

4) DEA License #: _____ Date Issued: _____ Expiration Date: _____

If you have no DEA, who will be writing prescriptions on your behalf? _____. (Please attach letter of coverage.)

If you have any of the following numbers, please enter below. Otherwise, please mark "N/A."

NPI: _____ Medicare: _____

If CCNV is maintaining the CAQH profile, the information below is required.

CAQH Number: _____ **CAQH Username:** _____ **CAQH Password:** _____

4. Hospital Affiliation

List all hospitals where you have had, or currently have privileges, and indicate current status. If you do not have current and active admitting privileges, or if they are pending, please include a written statement delineating your organization's inpatient coverage arrangement. If you require additional space, complete on a separate page and attach with application.

1) Institution Name: _____

Address: _____

Current Privilege Status: ☐ Active ☐ Courtesy ☐ Lapsed ☐ Provisional ☐ Allied ☐ Other: _____

2) Institution Name: _____

Address: _____

Current Privilege Status: ☐ Active ☐ Courtesy ☐ Lapsed ☐ Provisional ☐ Allied ☐ Other: _____

3) Institution Name: _____

Address: _____

Current Privilege Status: ☐ Active ☐ Courtesy ☐ Lapsed ☐ Provisional ☐ Allied ☐ Other: _____

5. Board or Professional Assocation/Certification

If you are board certified, please indicate the following:

Primary practice specialty: _____ Certification date: _____ Expiration Date: _____

Name of Certifying Board: _____

Secondary practice specialty: _____ Certification date: _____ Expiration Date: _____

Name of Certifying Board: _____

If you are not board certified, please indicate the following:

☐ I have taken the Board exam for _____ on _____ (date) and the results are pending.

☐ I am scheduled to take the Board exam for _____ on _____ (date).

☐ I am not planning to seek board certification at this time, and will be submitting continuing medical education (CME) credits instead. Number of CME credits attached: _____. (Minimum 60, must be completed in last 2 years.)

☐ I am a recent graduate, or my practice specialty does not require board certification.

6. Education and Training

Please provide appropriate contact information for all listed institutions, including correct campus name and complete mailing address.

1) **Medical/Professional School** name: _____

Address: _____
Street City State Zip

Degree Obtained: _____ Start Date: _____ (MM/DD/YY) End Date: _____ (MM/DD/YY)

ECFMG Number: _____ *(Foreign Medical School Graduates ONLY)*

2) **Internship** Specialty: _____ Program Director Name: _____ Fax Number: _____

Institution Name: _____ Affiliated University: _____

Address: _____
Street City State Zip

Start Date: _____ (MM/DD/YY) End Date: _____ (MM/DD/YY) **Email Address:** _____

3) **Residency** Specialty: _____ Program Director Name: _____ Fax Number: _____

Institution Name: _____ Affiliated University: _____

Address: _____
Street City State Zip

Start Date: _____ (MM/DD/YY) End Date: _____ (MM/DD/YY) **Email Address:** _____

4) **Fellowship** Specialty: _____ Program Director Name: _____ Fax Number: _____

Institution Name: _____ Affiliated University: _____

Address: _____
Street City State Zip

Start Date: _____ (MM/DD/YY) End Date: _____ (MM/DD/YY) **Email Address:** _____

7. Work History

Please attach a **current** copy of your Curriculum Vitae, including all positions held since completion of your professional degree. Please include addresses for previous places of employment where possible. The date format **must** be month/year format to verify and ensure no gaps in work history greater than 6 months are present.

Please provide an explanation of any gaps greater than six months in your work history in the space below.

8. Malpractice History

Please provide **5 YEARS** of malpractice coverage history in the space below. Dates **must** be in month/year format to verify coverage. If you have a copy of the malpractice certificates, please include with this application. If you need more space, please continue on a separate sheet and include with the application.

9. Liability Insurance Information

Please provide current FTCA certificate and deeming letter or Malpractice Certificate of Insurance.

Insurance carrier name: _____

Address: _____
Street City State Zip

Agent Name: _____ Phone Number: _____

Policy #: _____ Effective Date: _____ Expiration Date: _____

Amount of coverage per occurrence: _____ Aggregate coverage amount: _____

10. Academic Appointment

Institution Name: _____ Department: _____

Address: _____
Street City State Zip

Type of appointment: _____ Start Date: _____ Expiration Date: _____

Institution Name: _____ Department: _____

Address: _____
Street City State Zip

Type of appointment: _____ Start Date: _____ Expiration Date: _____

11. Other Certifications

Cardio-Pulmonary Resuscitation (CPR):	☐ Yes ☐ No	Certification Date: _____
Basic Life Support (BLS):	☐ Yes ☐ No	Certification Date: _____
Advanced Cardiac Life Support (ACLS):	☐ Yes ☐ No	Certification Date: _____
Advanced Life Support in OB (ALSO):	☐ Yes ☐ No	Certification Date: _____
Pediatric Advanced Life Support (PALS):	☐ Yes ☐ No	Certification Date: _____
Advanced Trauma Life Support (ATLS):	☐ Yes ☐ No	Certification Date: _____
Neonatal Advanced Life Support (NALS):	☐ Yes ☐ No	Certification Date: _____

12. Professional References

Please list 3 professional peer references willing to provide written comments, upon request, regarding your professional competence, ethics, character, health status and ability to work cooperatively with others. Professional peer references must be currently licensed, of the same specialty, and able to adequately assess your ability to practice at your current level. *This means that all referrals must be in your field of practice and must be at your level or above.* If you are just completing training, please use your Residency/Fellowship Program Director and/or the Chairperson of the Department. (Please limit to one office associate.)

Please provider a phone number for all references and AT LEAST a fax number or email provided. If one of those two is not present, CCNV will request an additional reference in order to complete credentialing.

1) Name: _____ Title: _____ Known Since: _____

Address: _____
Street City State Zip

Phone: _____ Fax: _____ Email: _____

In what capacity did this individual observe your performance? _____

2) Name: _____ Title: _____ Known Since: _____

Address: _____
Street City State Zip

Phone: _____ Fax: _____ Email: _____

In what capacity did this individual observe your performance? _____

3) Name: _____ Title: _____ Known Since: _____

Address: _____
Street City State Zip

Phone: _____ Fax: _____ Email: _____

In what capacity did this individual observe your performance? _____

4) Name: _____ Title: _____ Known Since: _____

Address: _____
Street City State Zip

Phone: _____ Fax: _____ Email: _____

In what capacity did this individual observe your performance? _____

CCNV Application
Confidential Attestation Questions

If you answer "yes" to any questions 1-8, please complete Section A, on the following page. If you answer "yes" to questions 9-10, please complete Section B, on the following page. Completion and signature of this page is **REQUIRED.**

1) Do you presently have, or have you ever had, any condition, mental, physical or emotional, including alcohol abuse, which would limit or impair or has in the past limited or impaired your ability to provide safe, effective medical care to your patients, with or without accommodation?.....Yes ☐ No ☐ N/A ☐

2) Are you now or have you ever been an active or habitual user of any illegal or controlled substance?.....Yes ☐ No ☐ N/A ☐
If so, are you now an active or habitual user of any illegal or controlled substance?.....Yes ☐ No ☐ N/A ☐

3) Are you now receiving or have you ever received treatment for any chemical dependency or substance abuse, including alcohol?
.....Yes ☐ No ☐ N/A ☐

4) Have any of the following below **ever** been or are in the process of being, **voluntarily or involuntarily,** withdrawn, relinquished, not renewed, expired, reduced, limited, placed on probation, denied, revoked, suspended, terminated, fined, limited, challenged, penalized, sanctioned, investigated, or otherwise negatively affected, including voluntary lapse in license or privilege due to relocation:

a) State license?.....Yes ☐ No ☐ N/A ☐
b) DEA or CDS registration, or other controlled substance authorization? .....Yes ☐ No ☐ N/A ☐
c) Hospital or other health care facility staff membership or privileges, or specific clinical privileges?.....Yes ☐ No ☐ N/A ☐
d) Professional organization membership?.....Yes ☐ No ☐ N/A ☐
e) Medicare, Medicaid, or other government health plan participation?.....Yes ☐ No ☐ N/A ☐
f) HMO, PPO, PHO, IPA or any other health plan participation?.....Yes ☐ No ☐ N/A ☐
g) Educational or training institution or program?.....Yes ☐ No ☐ N/A ☐
h) Academic appointment?.....Yes ☐ No ☐ N/A ☐
i) Medical or professional society or association, or professional board certification?.....Yes ☐ No ☐ N/A ☐

5) Are any actions currently pending against you by any federal or state regulatory or disciplinary authority, or by any hospital or provider?
.....Yes ☐ No ☐ N/A ☐

6) Have you ever resigned in order to avoid revocation, suspension, or reduction of privileges at any facility or institution?
.....Yes ☐ No ☐ N/A ☐

7) Have you been convicted or indicted of a crime, or are you under indictment for an alleged crime?.....Yes ☐ No ☐ N/A ☐

8) Has your professional liability insurance ever been limited, denied, suspended, canceled, lapsed, not renewed, special rated or experienced gaps?.....Yes ☐ No ☐ N/A ☐

9) Are you now, or have you ever been involved in any malpractice action(s), including litigation, arbitration or mediation, regardless of the outcome that resulted?.....Yes ☐ No ☐ N/A ☐

10) Has a payment to resolve or avoid any allegation(s) concerning your competence, conduct, or quality of care (not including litigation, arbitration or mediation) ever been paid by you or on your behalf?.....Yes ☐ No ☐ N/A ☐

11) Are you performing within the scope of your professional licensure?.....Yes ☐ No ☐ N/A ☐

12) Do you currently have malpractice coverage? (Through your current employer or otherwise.).....Yes ☐ No ☐ N/A ☐

I certify that the information provided in this document is complete and accurate. I understand that any misrepresentation may result in my non-selection, or if discovered after selection, in my termination as a network provider. I understand that this document, as part of my CCNV application, does not entitle me to participate in the CCNV Network. I agree to notify CCNV in a timely manner of any change to the information requested in this application.

Print Name: _____ **Signature:** _____ **Date:** _____

Section A: Sanctions Information

Please complete this form if you answered "yes" to questions 1-8 on the previous page. Explanations must be provided for all "yes" questions. Providers undergoing recredentialing do not need to complete this section if explanations for all "yes" answers have been provided during previous credentialing. CCNV reserves the right to request updated documentation if further information is needed during the credentialing process.

_____

_____

_____

_____

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_____

Section B: Malpractice Claims History

Please complete this form for all history of malpractice claims. Please fill out one form for each individual malpractice claim. All questions must be answered completely. Providers undergoing recredentialing do not need to complete this section if this form has been completed for all malpractice claims during previous credentialing. CCNV reserves the right to request updated documentation if further information is needed during the credentialing process.

Date of Occurrence: _____ Date claim was filed: _____ Professional Liability Carrier: _____

Patient Name: _____ Name of plaintiff, if other than patient: _____

Location of incident: _____

You were (choose one): Primary Defendant ☐ Co-Defendant ☐ Other Defendants (if any): _____

Describe in detail the allegation(s) against you: _____

_____

_____

Describe in detail the alleged injury to the patient: _____

_____

_____

Was suit filed in court? Yes ☐ No ☐ If yes, please attach any and all court documentation related to this suit.

Present status of the claim/case (include amount awarded/attributed/of settlement):

☐Pending ☐Arbitrated ☐On Appeal ☐Settled ☐Adjudicated (to verdict) ☐Mediated ☐Dismissed ☐Other_____

Amount Sued For: _____ Amount of award/settlement: _____

Print Name: _____ **Signature:** _____ **Date:** _____

CCNV CREDENTIALS VERIFICATION AUTHORIZATION AND RELEASE

I understand and acknowledge that, as an applicant for participation with Community Care Network of Virginia, Incorporated (CCNV) and other third party payors who may delegate credentialing activities to CCNV, as applicable, it is my responsibility to provide sufficient information upon which a proper evaluation can be undertaken of my current licensure, relevant training and/or experience, professional competence, character, ethical qualifications and any other criteria adopted for participation, and for resolving any questions about such information.

I further understand and acknowledge that CCNV will investigate the information provided in this application. By submitting this application, I agree to such investigation and to the reporting and information exchange activities of CCNV, third party payors, and health care facilities as a part of the CCNV Credentials Program, as follows:

I hereby authorize all individuals, institutions, and entities who have knowledge concerning information requested in this application to consult with and release relevant information to CCNV, third party payors, health care facilities, their employees and agents. I further authorize CCNV to release all such information to all health care facilities and third party payors that participate in the CCNV Credentials Program and with which I am affiliated.

I hereby fully, absolutely, and unconditionally release from liability facilities, CCNV, third party payors, and their employees and agents and all other individuals, institutions and entities providing information in accordance with the authorizations contained herein for all their acts performed in good faith and without malice in connection with the investigation of this application and the release and exchange of information authorized above, including but not limited to the acts of preparing or completing any verifications, evaluations, recommendations, information requests, or forms that are provided by the applicant, CCNV, health care facilities, or third party payors. This release shall be in addition to any other applicable immunities provided by law for peer review activities or otherwise.

I consent to the release of information and I authorize release of information and copies of related records and/or documents to CCNV to include not only the requested information for verification but information concerning each lawsuit, civil action, or other claim brought against me for malpractice or negligence; each disciplinary action under consideration or taken; any open or previously conclude investigations; and any changes in the status of a credential and all supporting documentation related to the information provided.

I understand and agree that the authorizations and releases given by me herein shall be irrevocable so long as I am an applicant for or have staff privileges at any health care facility participating in CCNV's Credentials Program, and/or so long as I am participating with one or more third party payors delegating credentialing activities to CCNV.

I understand and acknowledge that CCNV is involved in querying the National Practitioner Data Bank, American Medical Association, Board of Medicine, and other entities as recommended by The National Committee for Quality Assurance.

I understand and acknowledge the principle of ethics with the American Medical Association, American Osteopathic Association, or other appropriate professional organizations.

I acknowledge that the investigation of information in this application and the release of information by the facilities, CCNV, and third party payors and their employees and agents are done to improve the quality of patient care. I agree to notify the CCNV credentialing department of any changes to the information provided within thirty (30) days of any such change – including ANY actions placed against my license or any certification that I hold.

All information provided by me in this application is true to the best of my knowledge and belief, and free of omissions. I understand and agree that any material misstatement in or omission from this application may constitute grounds for denial of participation or for summary dismissal from the medical staff and/or third party payors. I understand and acknowledge that participation in CCNV applies to participation in the Network activities only, and that health care facilities shall be solely responsible for all decisions concerning medical staff membership, and that third party payors shall be solely responsible for all decisions concerning participation with such third party payors. I further understand and acknowledge that CCNV shall have no responsibility or liability with respect to medical staff membership decisions by health care facilities or participation decisions by third party payors.

I understand and agree that I have the right to review information submitted in support of my application and to correct erroneous information provided by either myself or an outside organization.

I further acknowledge that I have read and understand the foregoing authorization and release.

A photocopy of this Authorization and Release shall be as effective as the original.

_____ _____

Signature Date

_____

Print Name

Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature*

Name (print)*

M M D D Y Y Y Y

DATE SIGNED*

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.