

Memorial Hospital & Health System™

Practitioner Membership Application

Thank you for your interest in medical or allied health staff membership at Memorial Hospital. In accordance with our bylaws, rules, regulations and policies, there are minimum requirements that must be met in order to qualify for consideration of appointment to the medical or allied health staff. For that reason, please review the requirements listed below, and, if you meet those requirements, you may complete the Practitioner Application for Memorial Hospital and Health System.

- Currently valid unlimited license to practice. (*Indiana licensure is required prior to appointment.*)
- MD, DO, DDS, DDM, DPM, PhD, Psy D, APRN, or PA Degree
- Successful completion of an approved training program in a field applicable to the clinical privileges being requested. (*Applicants currently in a training program can apply if the program will be completed within 6 months of the date the application is submitted and a letter noting the anticipated date of program completion and signed by the Program Director is submitted with the application.*)
- Current Board Certification or certification within the time frame stipulated by the national certifying board pertaining to the privileges requested, or, if not so stipulated, certification must be within five years after completion of residency/fellowship training. (*Not required of dentists*)

If, upon receipt of your application, it is found that you do not meet medical/allied health staff requirements, your application will be deemed incomplete and will not be processed.

Completion of Application Form

Please complete the application in its entirety. If a section is not pertinent, indicate “N/A.” (Do **not** indicate “*see CV.*”) Ensuring that all areas of the application, including addresses, are complete will help facilitate the credentialing process.

Temporary Privileges

Temporary privileges cannot be considered until all information has been submitted and verified, then reviewed by the appropriate department chair and Credentials Committee with no identified issues. Therefore, it is important that you return the application and all requested information as soon as possible to allow adequate time for processing.

A file is deemed to be complete when:

- All blanks on the application form are filled in and necessary additional explanations are provided.
- Letters of reference and information from all medical education and practice affiliations (including military) have been received and are consistent with information provided in the application.
- All items requested have been received.

Credentialing Process

After your credentials file is deemed complete, your application will be processed through the appropriate Medical Staff Committees. The Board of Trustees has final authority in granting Medical Staff membership and/or privileges. You may expect an interval of approximately six weeks or longer from the time you submit an application to the Medical Staff Office until you receive notification of the Board of Trustees' decision regarding your Staff appointment.

Medical Staff Bylaws

Please visit our website at www.qualityoflife.org/docs to view the Medical Staff Bylaws, Rules and Regulations, and other policies/procedures (*under Quick Action Links*). Please review these documents and become familiar with them.

If you're printing this application from the Internet (Qualityoflife.org) please contact the Medical Staff Office at 574-647-7920 or mweaver@memorialsb.org for your specific privileging form.

MEMBERSHIP APPLICATION CHECKLIST

DOCUMENTATION REQUIREMENTS

Please indicate the following items as being enclosed, forthcoming, or not applicable.

<u>Enclosed</u>	<u>Forthcoming</u>	<u>Not Applicable</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Application Fee, made payable to Memorial Hospital: \$300 for Medical Staff membership (MD, DO, DDS, DMD, DPM) \$150 for Allied Health Staff Membership (PhD, Psy D, APR, PA)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	All applicants must submit 2 photos. (1) A clear photo suitable for submission in our physician directory and which will be included in our verification letters, and (2) a notarized copy of a valid driver's license. (Must be received with application)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Current Curriculum Vitae</u> including a work history in month/year format for the past 10 years, including military history.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>If not a US citizen, copy of valid work authorization.</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Copy of your professional / medical school diploma.</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Copy of your ECFMG certificate, if applicable.</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Copy of all Internship, Residency and Fellowship Certificates</u> , including foreign programs (where applicable).
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Copy of all board certificates</u> , when applicable, or a copy of letter indicating your admissibility to take the boards.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Copy of all current state licenses.</u> (Please note that Indiana license is required to apply for Managed Care plan.)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Comparative data from your most recent full year of hospital practice. This includes relevant practitioner-specific data such as numbers and types of surgical or invasive procedures, deliveries, OR specific diagnoses of admissions, as well as aggregate data, when available. Morbidity and mortality should be included when available. It is recognized that physicians just out of residency may not have this information; in this case, residency logs can be submitted.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Copy of Indiana Controlled Substance Certificate</u> that shows drug schedules.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Copy of current Federal DEA Registration Certificate.</u> (If coming to Indiana from out-of-state, evidence of application to transfer must be included.)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Copy of the facesheet from your current malpractice provider.</u> (Participation in the Indiana Patient Compensation Fund is required.)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Malpractice Claims History for the past 10 years.</u> A written explanation for each malpractice case open or closed is required.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Copy of recent PPD Test Results.</u> (within the past 12 months)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Copy of DD214 if former military personnel.</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>APRNs & PAs:</u> Copy of the Collaborating Practice Agreement with a medical staff member.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Copy of marriage license or legal documentation of any name changes.</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Written explanation of any time gaps</u> in work history or training since completion of professional/medical school.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Written explanation and documentation of any suspended or revoked licensure or privileges.</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Letter confirming NPI number</u> from the Provider Enumeration System.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Any explanations requested elsewhere in this application.</u>

MEMORIAL HOSPITAL & HEALTH SYSTEM

Practitioner Membership Application

- Medical Staff** (Please check this box if you are a doctor of medicine, dentistry, osteopathy, or podiatry.)
- Memorial Medical Group** (Please check this box if you are entering into a contract with Memorial Medical Group.)
- Allied Health Staff Mid-Level Professional** (Please check this box if you have a doctorate, advanced practice nurse, or physician assistant degree.)

INSTRUCTIONS: This form should be **typed** or **carefully printed**. If more space is needed, attach additional sheets and refer to the question being asked. **All** sections of this application must be completed using full addresses and names. If a section is not applicable, please mark it "N/A." **(INCOMPLETE APPLICATIONS WILL BE RETURNED)**

PERSONAL INFORMATION

Last Name (include suffix, i.e., Jr., Sr., III)	First Name	Middle Name	Degree
Other name by which you have been known? Last: _____ First: _____ Middle: _____			
Date of Birth	Place of Birth (City/State/Country)	Social Security Number	
Home Street Address	Home City/State/Zip	Home Phone Number <input type="checkbox"/> Listed <input type="checkbox"/> Unlisted	
Primary E-Mail Address (Required)	Cell Phone Number	Pager Number	
Spouse Name	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Other Non-English Languages You Speak	
If not a United States citizen, can you provide evidence of your legal right to work in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable			

PRACTICE INFORMATION

Practice Name	If not currently practicing at this location, when do expect to start?	Check all applicable boxes: <input type="checkbox"/> Primary Office <input type="checkbox"/> Secondary Office <input type="checkbox"/> Mailing Address <input type="checkbox"/> Billing Address
Office Street Address		<input type="checkbox"/> Full time practice <input type="checkbox"/> Part time practice <input type="checkbox"/> PRN
Office City/State/Zip		
Office Phone Number	Office Fax Number	Office Answering Service Number
Office Manager / Business Contact	Manager/Contact Phone No	Manager/Contact E-mail Address
Practice Name		Check all applicable boxes: <input type="checkbox"/> Primary Office <input type="checkbox"/> Secondary Office <input type="checkbox"/> Mailing Address <input type="checkbox"/> Billing Address
Office Street Address		<input type="checkbox"/> Full time practice <input type="checkbox"/> Part time practice <input type="checkbox"/> PRN
Office City/State/Zip		
Office Phone Number	Office Fax Number	Office Answering Service Number
Office Manager / Business Contact	Manager/Contact Phone No	Manager/Contact E-mail Address

LICENSE, CERTIFICATIONS, AND OTHER IDENTIFICATION NUMBERS

(List all current and past professional state licenses)

(If you have not applied for your Indiana State License, you can do so at <http://www.in.gov/hpdb/licenseapp>. Please note that Indiana requires you to submit an NPDB self query. It is also recommended that you ask for a temporary license and Controlled Substance to expedite the process.)

Type	License/Certificate Number	Issue Date	Expiration Date	State of Registration	Do You Currently Practice in This State?	
State License					<input type="checkbox"/> Yes	<input type="checkbox"/> No
State License					<input type="checkbox"/> Yes	<input type="checkbox"/> No
State License					<input type="checkbox"/> Yes	<input type="checkbox"/> No
State License					<input type="checkbox"/> Yes	<input type="checkbox"/> No
If you do not have an Indiana State License, have you applied?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
					If No, date you applied:	
State Controlled Substance Certificate				<input type="checkbox"/> Not Applicable / I do not prescribe controlled substances and therefore am not required by law to have a DEA certificate.		
DEA Registration Certificate				<input type="checkbox"/> Not Applicable / I do not prescribe controlled substances and therefore am not required by law to have a DEA certificate.		
NPI No.		Medicare Provider No.			Medicaid Provider No.	

BOARD/PROFESSIONAL CERTIFICATION

Specialty	Primary	Secondary	Board Certified (Yes or No)		Date Certified	Date Recertified	Expiration Date
			Y	N			
			Y	N			
			Y	N			
			Y	N			
			Y	N			

If not Board Certified, indicate any of the following that apply:

- I have taken the exam, results pending for: _____ (Board)
- I am scheduled to sit for the exams on: _____ (Date)
- I am not planning to take the Boards.

Yes No Have you ever been examined by a Certifying board but failed to pass? If Yes, indicate the number of times the examination was taken:

Yes No Has your board certification been suspended or revoked, or are such actions currently pending? Please explain if Yes.

Yes No Have you lost any board certification(s), and/or failed to re-certify voluntarily or involuntarily? Please explain if Yes.

CLINICAL TEACHING APPOINTMENTS

Institution	Position	From (mm/dd/yy)	To (mm/dd/yy)
Street Address	City/State/Zip	Program Director	
Phone Number	Fax Number	E-Mail Address	
Name of Institution	Position	From (mm/dd/yy)	To (mm/dd/yy)
Street Address	City/State/Zip	Program Director	
Phone Number	Fax Number	E-Mail Address	

EDUCATION AND TRAINING (Please account for all time since graduation from professional school, listing alternate or additional schooling. If more than one program was begun or completed, please supply that information.)

Undergraduate School

Official Name of School:	Dates Attended: (mm/dd/yy) From : To:	Degree Obtained
Street Address	City/State/Zip	Date of Graduation:

Medical or Professional Education

Graduate Type:	<input type="checkbox"/> US or Canadian	<input type="checkbox"/> Non US or Canadian	ECFMG No.	<input type="checkbox"/> Fifth Pathway
Official Name of School:	Street Address		Start Date: (mm/dd/yy)	
Degree Obtained	City/State/Zip		Graduation Date: (mm/dd/yy)	
Did you complete your graduate education at this school? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Post Graduate Training & Experience

<input type="checkbox"/> Internship	<input type="checkbox"/> Residency	<input type="checkbox"/> Fellowship
Institution	From: (mm/dd/yy)	To: (mm/dd/yy)
Address	City/State/Zip	Specialty
Phone Number	Fax Number	Program Director
E-Mail Address	Did you successfully complete the program? (If no, please explain) <input type="checkbox"/> Yes <input type="checkbox"/> No	

<input type="checkbox"/> Internship	<input type="checkbox"/> Residency	<input type="checkbox"/> Fellowship
Institution	From: (mm/dd/yy)	To: (mm/dd/yy)
Street Address	City/State/Zip	Specialty
Phone Number	Fax Number	Program Director
E-Mail Address	Did you successfully complete the program? (If no, please explain) <input type="checkbox"/> Yes <input type="checkbox"/> No	

<input type="checkbox"/> Internship	<input type="checkbox"/> Residency	<input type="checkbox"/> Fellowship
Institution	From: (mm/dd/yy)	To: (mm/dd/yy)
Street Address	City/State/Zip	Specialty
Phone Number	Fax Number	Program Director
E-Mail Address	Did you successfully complete the program? (If no, please explain) <input type="checkbox"/> Yes <input type="checkbox"/> No	

<input type="checkbox"/> Internship	<input type="checkbox"/> Residency	<input type="checkbox"/> Fellowship
Institution	From: (mm/dd/yy)	To: (mm/dd/yy)
Street Address	City/State/Zip	Specialty
Phone Number	Fax Number	Program Director
E-Mail Address	Did you successfully complete the program? (If no, please explain) <input type="checkbox"/> Yes <input type="checkbox"/> No	

HOSPITAL AND OTHER HEALTH CARE FACILITY AFFILIATIONS

(Please list in chronological order, with current affiliations first, all health care institutions where you have or have had clinical privileges and/or staff membership. Include current affiliations, applications in process, and previous hospitals and other facility affiliations (e.g., hospitals, surgery centers, or any health care related facility. Do not list residencies, internships or fellowships. List employment in Professional Practice/Work History.)

<input type="checkbox"/> Current	<input type="checkbox"/> Prior	<input type="checkbox"/> Pending	Staff Status	
Institution			From: (mm/dd/yy)	To: (mm/dd/yy)
Street Address		City/State/Zip		Department
E-Mail Address		Phone Number		Fax Number
<input type="checkbox"/> Current	<input type="checkbox"/> Prior	<input type="checkbox"/> Pending	Staff Status	
Institution			From: (mm/dd/yy)	To: (mm/dd/yy)
Street Address		City/State/Zip		Department
E-Mail Address		Phone Number		Fax Number
<input type="checkbox"/> Current	<input type="checkbox"/> Prior	<input type="checkbox"/> Pending	Staff Status	
Institution			From: (mm/dd/yy)	To: (mm/dd/yy)
Street Address		City/State/Zip		Department
E-Mail Address		Phone Number		Fax Number
<input type="checkbox"/> Current	<input type="checkbox"/> Prior	<input type="checkbox"/> Pending	Staff Status	
Institution			From: (mm/dd/yy)	To: (mm/dd/yy)
Street Address		City/State/Zip		Department
E-Mail Address		Phone Number		Fax Number
<input type="checkbox"/> Current	<input type="checkbox"/> Prior	<input type="checkbox"/> Pending	Staff Status	
Institution			From: (mm/dd/yy)	To: (mm/dd/yy)
Street Address		City/State/Zip		Department
E-Mail Address		Phone Number		Fax Number

PROFESSIONAL PRACTICE/WORK HISTORY (Chronologically list and account for all periods of time from the date of entry into medical/professional school to present, including work, professional and practice history activities since completion of postgraduate training, and military service. (Do not include hospital affiliations listed elsewhere on this application))

Name of Practice/Institution	Supervisor	From:(mm/dd/yy)	To: (mm/dd/yy)
Street Address	City/State/Zip	Department/Privileges/Rank/Status	
E-Mail Address if available	Phone Number	Fax Number	
Name of Practice/Institution	Supervisor	From:(mm/dd/yy)	To: (mm/dd/yy)
Street Address	City/State/Zip	Department/Privileges/Rank/Status	
E-Mail Address if available	Phone Number	Fax Number	
Name of Practice/Institution	Supervisor	From:(mm/dd/yy)	To: (mm/dd/yy)
Street Address	City/State/Zip	Department/Privileges/Rank/Status	
E-Mail Address if available	Phone Number	Fax Number	

Please explain any time periods or gaps greater than two (2) months since professional school to the present time. Use a separate sheet of paper if necessary. **Does Not Apply**

From (month/year)	To (month/year)	Explanation

PEER REFERENCES (Please list at least three references in the same professional discipline to whom you are not related or are not partners with and who have recent personal knowledge of your professional performance and competence. These references must include the program director if recently completing a training program, and/or the chief of the department at the institution where you most recently practiced.)

(1) List the Head of Clinical Service/Department at your current facility OR the person responsible for your training if you are presently in a training program.

Name of Reference	Specialty
Street Address	City/State/Zip
E-Mail Address	Phone Number
	Title
	Fax Number

(2) List other peer references below (preferably from facilities where you currently or most recently have practiced.)

Name of Reference	Specialty
Street Address	City/State/Zip
E-Mail Address	Phone Number
	Title
	Fax Number

Name of Reference	Specialty
Street Address	City/State/Zip
E-Mail Address	Phone Number
	Relationship
	Fax Number

Name of Reference	Specialty
Street Address	City/State/Zip
E-Mail Address	Phone Number
	Relationship
	Fax Number

PROFESSIONAL LIABILITY INSURANCE (Please list all carriers for the past five years)

<input type="checkbox"/> Pending	<input type="checkbox"/> Current		<input type="checkbox"/> Prior
Insurance Carrier	Policy Number	Effective Date	Expiration Date
Street Address	City/State/Zip		Phone Number
No. of Claims Filed with this Carrier: _____ Pending _____ Settled	Coverage Amounts: Occurrence: _____ Aggregate: _____		Fax Number
<input type="checkbox"/> Pending	<input type="checkbox"/> Current		<input type="checkbox"/> Prior
Insurance Carrier	Policy Number	Effective Date	Expiration Date
Street Address	City/State/Zip		Phone Number
No. of Claims Filed with this Carrier: _____ Pending _____ Settled	Coverage Amounts: Occurrence: _____ Aggregate: _____		Fax Number
<input type="checkbox"/> Pending	<input type="checkbox"/> Current		<input type="checkbox"/> Prior
Insurance Carrier	Policy Number	Effective Date	Expiration Date
Street Address	City/State/Zip		Phone Number
No. of Claims Filed with this Carrier: _____ Pending _____ Settled	Coverage Amounts: Occurrence: _____ Aggregate: _____		Fax Number

If the answer to any of the following questions is "Yes" please give the full details on a separate sheet of paper and attach. For each claim of malpractice of professional liability asserted against you, please complete Attachment A. For each claim or complaint, you may supplement attachment A with a prepared statement. Completion of Attachment A is critical for the credentialing process. The application is incomplete without this.

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever been denied or voluntarily relinquished your professional liability insurance coverage, and/or have had your professional liability insurance coverage canceled, non-renewed or limits reduced?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you been denied professional liability insurance coverage or rated in higher-than-average risk class for your professional specialty?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have any professional liability suits ever been entered against you?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have any professional liability claim settlements ever been paid by you and/or paid on your behalf.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are there any currently pending professional liability suits, actions and/or claims filed against you?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has any person or entity ever been sued for your clinical action?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has your present professional liability insurance carrier excluded any specific procedures?

MEDICAL STAFF CATEGORY AND DEPARTMENT

This section only pertains to those requesting medical staff membership.

STAFF CATEGORY: (Refer to the description of staff categories in Article Four of the Medical Staff Bylaws)

Please check the staff category that will reflect your practice at Memorial Hospital.

<input type="checkbox"/> Attending	<input type="checkbox"/> Affiliate	<input type="checkbox"/> Consulting	<input type="checkbox"/> Locum Tenens
Practitioners seeking Attending staff status will be assigned to Conditional Attending status for one year, after which they are transferred to Attending status. Consulting Staff members must be invited to apply for consulting status by the Board or Medical Executive Committee. Affiliate staff has no privileges and is a membership only category. Locum Tenens are appointed for a maximum period of one year.			

CALL COVERAGE: All practitioners must assure timely, adequate professional care for their patients in the Hospital by being available or having available, through their office or answering service, an eligible alternate physician with whom prior arrangements have been made and who has at least equivalent clinical privileges at the Hospital. **List the names of practitioners with equivalent privileges who will provide call coverage for your patients when you are not available:**

DISCLOSURE QUESTIONS (Please answer each of the following questions. If the answer to any of the questions is Yes, please provide a full explanation of the details on a separate sheet of paper and attach.)

LICENSURE/DEA OR CONTROLLED SUBSTANCE REGISTRATION

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended, revoked, canceled, and/or subject to probation either voluntarily or involuntarily, or has your application for a license ever been withdrawn?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever been reprimanded and/or fined, been the subject of a complaint and/or have you been notified in writing that you have been investigated as the possible subject of a criminal, civil or disciplinary sanction by any state or federal agency which licenses providers?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has your federal DEA number and/or state controlled substances license been restricted, limited, relinquished, suspended or revoked, either voluntarily or involuntarily, and/or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action with respect to your DEA or Controlled Substance Registration?

EDUCATION AND TRAINING

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other education program?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Did you have a voluntary or involuntary leave for 30 or more consecutive days during an internship, residency, fellowship, preceptorship, or other clinical education program?

HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have your clinical privileges or membership at any hospital, ambulatory surgery center, managed care organization, military service, or any other health care organization ever been voluntarily or involuntarily suspended, reduced, restricted, revoked, relinquished, denied, placed on probation, placed under mandatory consultation, or not renewed, for reasons other than non-completion of medical records when quality of care was not adversely affected, or have proceedings toward any of those ends been instituted or recommended?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever voluntarily or involuntarily withdrawn your application for appointment or failed to seek renewal of your hospital or ambulatory surgery center privileges, or resigned while under investigation?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever been the subject of any formal disciplinary or professional misconduct proceedings at any health care facility, physician organization, or other professional organization or society, or are any investigations pending?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever been the subject of focused individual monitoring at any hospital or health care facility?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever been denied membership or renewal or been subject to disciplinary action by any medical organization, managed care organization, or professional society, local, state, or national, or have proceedings toward any of those ends ever been instituted, recommended, or are any currently pending?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you, or any of your hospital or ambulatory surgery center privileges and/or membership been denied, revoked, suspended, reduced, placed on probation, proctored, placed under mandatory consultation or non-renewed?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you voluntarily or involuntarily relinquished or failed to seek renewal of your hospital or ambulatory surgery center privileges for any reason?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have any disciplinary actions or proceedings been instituted against you and/or are any disciplinary actions or proceedings now pending with respect to your hospital or ambulatory surgery center privileges and/or your license?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?

MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you been denied membership and/or been subject to probation, reprimand, sanction or disciplinary action, or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action by any health care organization, e.g., hospital, HMO, PPO, IPA, professional group or society, licensing board, certification board, PSRO or PRO?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have Medicare, Medicaid, CHAMPUS, PRO authorities and/or any other third party payors brought charges against you for alleged inappropriate fees and/or quality-of-care issues?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you withdrawn an application or any portion of an application for appointment or reappointment for clinical privileges or staff appointment or for a license or membership in an IPA, PHO, professional group or society, health care entity or health care plan prior to a final decision to avoid a professional review or adverse decision?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever been reprimanded, censured, excluded, suspended and/or disqualified from participating, or voluntarily withdrawn to avoid an investigation, in any private, federal, or state health insurance program?

OTHER SANCTIONS OR INVESTIGATIONS

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has any information pertaining to you, including malpractice judgments and/or disciplinary action, ever been reported to the National Practitioner Data Bank (NPDB) and/or any other practitioner data bank?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?

CRIMINAL ACTIONS

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you been charged with or convicted of a crime (other than a minor traffic offense) in this or any other state or country and/or do you have any criminal charges pending other than minor traffic offenses in this state or any other state or country?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you been the subject of a civil or criminal complaint or administrative action or been notified in writing that you are being investigated as the possible subject of a civil, criminal or administrative action regarding sexual misconduct, child abuse, domestic violence or elder abuse?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has a patient, employee, or co-worker ever accused you of sexual harassment or other illegal misconduct?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?

ABILITY TO PERFORM REQUESTED PRIVILEGES

(If you answer affirmatively to any of the following questions with regards to a condition that would prevent you from performing all the functions and procedures associated with your privileges with or without reasonable accommodation according to accepted standards of professional performance and without posing a direct threat to patient care, and are found to be professional qualified for membership, you will be given an opportunity to determine what accommodations, if any, are necessary or feasible to allow you to practice safely.)

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you received your rubella immunization? If NO, please note whether you have had the disease. If you haven't, please obtain immunization and include proof of immunization with this application.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever been hospitalized or confined during the past five years for reasons that would affect your physical or mental ability to practice medicine in a safe manner?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you been treated for the use or misuse of prescription drugs or illegal substance chemicals within the past five years?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever had a problem with or been treated for alcoholism, addiction, or abuse of controlled substances?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you currently under the care of a physician for any condition that would affect your clinical practice?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you currently taking any medication that may affect either your clinical judgment or motor skills?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If you use alcohol and/or chemical substances, does your use in any way impair and/or limit your ability to practice medicine with reasonable skill and safety?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you currently participating in a supervised rehabilitation program and/or professional assistance program which monitors you for alcohol and/or substance abuse?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you currently engaged in illegal use of any legal or illegal substances?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you currently overuse and/or abuse alcohol or any controlled substance?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have a medical condition, physical defect or emotional impairment, which in any way impairs and/or limits your ability to practice medicine with reasonable skill and safety?

INVESTMENTS

<input type="checkbox"/> Yes	<input type="checkbox"/> No	In the last five (5) years have you and/or a member of your family purchased or made an investment in (other than securities of a publicly traded company), or otherwise have a business interest in any clinical laboratory, diagnostic or testing center, hospital, surgicenter, and/or other business dealing with the provision of ancillary health services, equipment or supplies?
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ADDITIONAL CERTIFICATIONS

(Do you hold the following certification? If Yes, please include a copy of current certificate.)

<input type="checkbox"/> Yes	<input type="checkbox"/> No	1. ACLS – Advanced Cardiac Life Support	Expiration Date:
<input type="checkbox"/> Yes	<input type="checkbox"/> No	2. ALSO – Advanced Life Support in OB	Expiration Date:
<input type="checkbox"/> Yes	<input type="checkbox"/> No	3. PALS – Pediatric Advanced Life Support	Expiration Date:
<input type="checkbox"/> Yes	<input type="checkbox"/> No	4. ATLS – Advanced Trauma Life Support	Expiration Date:
<input type="checkbox"/> Yes	<input type="checkbox"/> No	5. NALS – Neonatal Advanced Life Support	Expiration Date:
<input type="checkbox"/> Yes	<input type="checkbox"/> No	6. CPR – Cardiopulmonary Resuscitation	Expiration Date:
<input type="checkbox"/> Yes	<input type="checkbox"/> No	7. NRP – Neonatal Resuscitation Program	Expiration Date:

ATTACHMENT A MEDICAL MALPRACTICE REPORTING FORM

**This form must be completed for each malpractice claim, whether the current status is open or closed.
Please make additional copies when necessary.**

Status of Incident:			
<input type="checkbox"/> Pending	<input type="checkbox"/> Dismissed w/o payment	<input type="checkbox"/> Settlement	<input type="checkbox"/> Closed

1. Date of Incident:	Date Claim Filed:
2. Patient's Name:	Age:
3. Insurance Carrier:	Address:
4. What is your status: <input type="checkbox"/> Primary Defendent <input type="checkbox"/> Co-Defendent <input type="checkbox"/> Other (explain)	
5. Total Amount of Settlement/Judgment:	
6. Amount Paid on Your Behalf:	
7. Explain in detail the plaintiff's allegations:	
8. Explain in detail your defense to these allegations:	
10. Current status/outcome of the suit:	
11. Medical Malpractice Review Panel Decision:	

MEMORIAL HOSPITAL & HEALTH SYSTEM

STATEMENT OF AUTHORIZATION AND RELEASE

In making application to Memorial Health System, I hereby consent to the disclosure, inspection, and copying of information and documents relating to my credentials and qualifications ("peer review information") by and between "this Healthcare Organization" and other healthcare entities (e.g., hospital medical staffs, medical groups, independent practice associations (IPAs), health plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies (with respect to certification of coverage and claims history), licensing authorities, and businesses and individuals acting as their agents, collectively "Healthcare Entities,") for the purpose of evaluating this application and any recertification application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect peer review information from being further disclosed.

I am informed and acknowledge that the federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, and all persons and entities providing peer review information to such representatives of the Healthcare Organization, from any liability they might incur for their acts and/or communication in connection with evaluation of my qualifications for participation in this Healthcare Organization.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications, and for resolving any doubts about such qualifications. All provisions of this application have been completed or accompanied by an explanation of why answers are not available. I also understand that an application is deemed complete when an application is fully completed by the applicant, is accompanied by all requested supporting documents, and all other references and confirmations have been received by Memorial Health System. The burden of providing all data and the proof of information relating to the application is my responsibility. I hereby signify my willingness to appear for interview with representatives of the organization(s) to which I am applying in regard to my application.

During such time as this application is being processed, I agree to update this information should there be any change in the information provided. I also agree to notify the Healthcare Organization(s) to which I am applying in writing, within five (5) days of receiving any written or oral notice of any adverse action, including, without limitation, any filed and served malpractice suit or arbitration action; any adverse action by a Medical Licensing Board taken or pending, including but not limited to, any accusation filed, temporary formal restriction, probation, suspension, or revocation of licensure; any adverse action taken by any Healthcare Entity, which has resulted in the filing of a report with the Medical Board of Indiana, or a report with the National Practitioner Data Bank; any revocation of DEA license, a conviction of any felony, or a misdemeanor committed in the course of practice; any action against any certification under the Medicare or Medicaid programs; or any cancellation, non-renewal, or material reduction in medical liability insurance policy coverage, during the tenure of my membership and privileges if granted.

In applying to the Medical/Allied Health Staff of Memorial Hospital, I certify that I meet the general requirements for membership as outlined in the Medical Staff Bylaws and Allied Health Rules & Regulations. I understand that if I do not meet these requirements, or if I fail to provide such additional supporting information as may be requested; my application will not be processed. I have been informed to review the Medical Staff Bylaws and related manuals, including the Rules and Regulations of the Medical Staff and Allied Health Staff that are in force at the time of my application that are available for my review on the hospital website. I agree to be bound by the terms thereof in all matters, including the provision of continuous patient care.

I hereby affirm that the information submitted in this application and any addenda thereto is true and complete to the best of my knowledge and belief and is furnished in good faith. I understand that significant omissions, misstatements, or misrepresentations, whether intentional or not, may result in denial of my application or termination of my membership and privileges. I certify that I have the professional ability to provide patient care as requested under this application.

A photocopy of this document shall be as effective as the original.

Date: _____

Printed Name

Signature (stamped signature is not acceptable)

All references to "this Healthcare Organization " shall refer to the entity's to which this application is submitted, including their agents and representatives.

MEMORIAL HOSPITAL & HEALTH SYSTEM

615 N. Michigan Street
South Bend, IN 46601
Phone #574/647-7188 Fax #574/647-6691

CONSENT TO RELEASE INFORMATION REGARDING PROFESSIONAL LIABILITY INSURANCE

I, the undersigned, authorize my previous/present insurance carrier to release to Memorial Hospital any information regarding insurance claims filed against me -- pending, settled, and/or lost. I understand this information will be utilized only in making a recommendation for appointment.

I also authorize my present professional liability insurance carrier to send Memorial Hospital verification of my professional liability coverage (Certificate Holder). Therefore, Memorial Hospital is to be notified of the amount of my coverage and any future changes in my insurance status.

Signature: _____ Date: _____

MEDICARE PHYSICIAN ACKNOWLEDGMENT STATEMENT
AS REQUIRED BY FEDERAL REGULATIONS

"Notice to Physicians: Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws."

By affixing my signature, I hereby certify that I have received the notice stated above.

Physician's Signature

(Legal signature must be used, initials are not acceptable)

Date

Physician's Printed Name

**MEMORIAL HOSPITAL
MEDICAL STAFF INITIAL/SIGNATURE RECORD**

Please complete the following. This form assists Medical Records in identifying your signature.

Write your signature as it will appear in the medical record:

Full Signature: _____

If you will use any initials or any abbreviated form of your full signature, please indicate this below:

Abbreviated Form: _____

Please print your name: _____

PRACTITIONER ACCESS AGREEMENT

This agreement is made this _____ day of _____, 200__ between Memorial Hospital of South Bend, Inc.

(Memorial) and _____ (Physician).

WHEREAS Physician desires to have access to Memorial's patient information contained in its electronic medical records, and

WHEREAS such patient information is the sole property of Memorial and is protected health information, and

WHEREAS the parties desire to provide access to Physician under terms and conditions which will protect not only the privacy of the patient information but also Memorial's proprietary interest in the same.

NOW, THEREFORE for and in return for the mutual promises and obligations set out below the parties agree as follows:

- 1.) The term of this agreement shall be for one (1) year commencing on _____ and ending on _____, 200__.
- 2.) Prior to its expiration, this agreement may be terminated as follows:
 - a.) By written agreement of the parties upon the terms and conditions they agree upon.
 - b.) By either party upon sixty (60) days prior written notice setting out the termination date.
 - c.) By Memorial immediately for cause. Cause shall include but shall not be limited to improper or unauthorized access to Memorial's electronic medical record or unauthorized or improper disclosure of information they contain.
- 3.) Memorial will provide Physician with an access code (user name and password) which must be used to access Memorial's electronic medical record.
- 4.) Physician agrees that the access code is the equivalent of a legal signature and that Physician will be accountable and responsible for all work done using Physician's access code.
- 5.) Physician will not disclose Physician's access code to anyone. Moreover, Physician will not use an access code which is not one that is assigned to Physician.
- 6.) Physician will access data only for patients for whom Physician has a professional need to know, patients who are currently active patients, and only for the purposes that relate to the treatment of patient, consultation with another Physician who is treating the patient, or billing for services.
- 7.) Physician, without the express written consent of Memorial, will not add information to any electronic medical record.
- 8.) Physician will access only the data which Physician "needs to know" as that data is designated in Memorial's HIPAA minimum necessary policies in effect from time to time.
- 9.) Should Physician have reason to believe that Physician's access code has been disseminated, Physician will immediately contact Memorial to have Physician's access code changed.
- 10) Physician understands and agrees that any misuse of the confidential access code or violation of systems policies will be considered a violation of Memorial's policies and could subject Physician to disciplinary action. Specifically,
Physician acknowledges that the information to which Physician will be granted access involves confidential patient records, protected health information and other demographic information which is governed by various privacy laws. Physician further understands and agrees that access to this information will be routinely audited by Memorial personnel to insure that only properly authorized individuals with a "need to know" are accessing patient data. The patient data to which Physician will have access is the same data that is available in the patient's medical record and must be treated with the same degree of confidentiality with which the paper record is treated. In the event that the

Physician is accessing medical record information to which a Physician has no need to know, or if it is determined that Physician is otherwise misusing Physician's access capabilities, Physician's right of access may be revoked. Physician further understands and agrees that any such violation of confidentiality provisions may subject Physician to disciplinary action by Memorial's staff and/or board of directors. Physician further understands and agrees that HIPAA violations may lead to fines and imprisonment.

- 11) All of Physician's employees who will be given access to any of Memorial's electronic medical records shall be required to execute a confidentiality agreement in the form attached. Further, Physician will enforce said agreement by implementing policies prohibiting employees from accessing patient information in Memorial's electronic medical record that is not necessary for such employee's professional duties. Physician will enforce such policies by bringing appropriate disciplinary action for any violations and will immediately inform Memorial of any violation of such policies by any employee.
- 12) Physician will immediately inform Memorial of any employee termination so that said employee's access to Memorial's electronic medical record can be terminated.
- 13) Physician will enter into appropriate business associate agreements with any third parties with which Physician contracts to perform services on Physician's behalf and to which Physician provides Memorial patient information. If requested, Physician will provide Memorial with a copy of each of the business associate agreements referred to in this paragraph.
- 14) If Physician enters into a business associate agreement regarding access to Memorial patient information and if Physician becomes aware of any breaches of the agreement by the business associate or a violation by the business associate of Physician's agreement with Memorial, Physician will immediately inform Memorial of such breach or violation.
- 15) Prior to accessing Memorial data bases remotely through Physician's information system, Physician will obtain the written consent of Memorial.
- 16) Physician understands and agrees that Memorial cannot guarantee that Physician will always have access to Memorial's electronic medical records due to system breakdowns and other unforeseen technical difficulties. Accordingly, Physician agrees to release and hold harmless Memorial, its subsidiaries, affiliates, employees, directors and agents from and against any and all damages Physician may incur as a result of Physician's inability to access Memorial's information system at any given time.
- 17) Physician will identify those employees who shall have access to Memorial's electronic medical records. Said employees being listed on "Exhibit A" which is attached.
- 18) Physician understands and agrees that the electronic medical records shall at all times remain the exclusive property of Memorial. Physician shall not copy or store said records. This paragraph shall survive the termination of this agreement.
- 19) Physician agrees that Memorial would be irreparably harmed by a disclosure of the patient data and protected health information contained in Memorial's electronic medical records. Consequently, Physician agrees that in the event of a disclosure or a threatened disclosure, Memorial shall, in addition to any other remedy to which it might be entitled, be entitled to obtain a temporary restraining order, preliminary injunction and permanent injunction against the disclosure or threatened disclosure; all relief shall be available to Memorial without the necessity of posting a bond.
- 20) In the event of a breach, in addition to any other remedy to which it might be entitled, Memorial shall be entitled to recover its reasonable attorney fees and costs incurred in the enforcement of its rights hereunder.

Physician Name:

Memorial Health System Inc.

By: _____

By: _____

Title: Vice President Medical Staff Affairs

Please keep the following two pages for your files

MEDICAL STAFF CODE OF PROFESSIONAL BEHAVIOR

Approved:	MEC: 5/1/00	Board: 5/13/00	Amended: 2/28/2008
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Purpose:

To define the expected code of conduct for Medical Staff members and Allied Health Professionals.

Policy:

It is the policy of this Medical Staff that all individuals within its facilities be treated with courtesy, respect, and dignity. Professional behavior, ethics and integrity are expected of each individual member of the Medical and Allied Health Staff. This Code is a statement of the ideals and guidelines for professional and personal behavior of the Medical and Allied Health Staff in all dealings with patients, their families, other health professionals, employees, students, vendors, government agencies, society and among themselves, in order to promote the highest quality of patient care, trust, integrity and honesty.

Each practitioner has a responsibility for the welfare, well-being, and betterment of the patient being served. In addition, the practitioner has a responsibility to maintain his/her own professional and personal well-being, in addition to maintaining a reputation for truth and honesty.

Guidelines for Interpersonal Relationships

- Treat all medical staff, hospital staff, house staff or students, and patients with courtesy and respect
- You will not engage in the following behaviors:
 - Sexual harassment or making sexual innuendoes
 - Using abusive language or repetitive sarcasm
 - Making threats of violence, retribution, litigation, or financial harm
 - Making racial or ethnic slurs
 - Actions that are reasonably felt by others to represent intimidation
 - Using foul language, shouting, or rudeness
 - Criticizing medical staff, hospital staff, house staff, or students in front of others while in the workplace or in front of patients
 - Shaming others for negative outcomes
 - Physically or verbally slandering or threatening other physicians or health care professionals
 - Romantic and/or sexual relationships with your current or former patients. This extends to key third parties such as spouses, children or parents of patients
 - Revealing confidential patient or staff information to anyone not authorized to receive it
- Do not treat patients while impaired by alcohol, drugs, or illness. The patient would be placed at risk.
- Support and follow hospital policies and procedures; address dissatisfaction with policies through appropriate channels
- Use conflict management skills and direct verbal communication in managing disagreements with associates and staff
- Cooperate and communicate with other providers displaying regard for their dignity
- Be truthful at all times
- Wear attire that reflects your professional role and respects your patients
- Develop and institute a plan to manage your stress and promote your personal well being

Guidelines for Clinical Practice

- Respond promptly and professionally when called upon by fellow practitioners to provide appropriate consultation or clinical service
- Respond to patient and staff requests promptly and appropriately
- Respect patient confidentiality and privacy at all times; follow all regulations for release of information.
- Treat patient families with respect and consideration while following all applicable laws regarding such relationships (release of information, advance directives, etc.)
- Seek and obtain appropriate consultation

- Arrange for appropriate coverage when not available
- Do one's best to provide the best effective and efficient care
- Prepare and maintain medical records within established time frames
- Disclose potential conflicts of interest and resolve the conflict in the best interest of the patient
- When terminating or transferring care of a patient to another physician, provide prompt, pertinent, and appropriate medical documentation to assure continuation of care
- Refrain from accepting money, gifts or personal benefits from commercial healthcare companies when on-site at Memorial Hospital or affiliated sites

Guidelines for Relationship with Hospital and Community

- Abide by all rules, regulations, policies and bylaws of Memorial Hospital
- Serve on Hospital and Medical Staff committees
- Assist in the identification of colleagues who may be professionally impaired or disruptive
- Maintain professional skills and knowledge and participate in continuing medical education
- Refrain from fraudulent scientific practices
- Accurately present data derived from research
- Request appropriate approval from the Institutional Review Board (IRB) prior to human research activities and abide by all laws and regulations applying to these activities
- Follow and obey the law of the land and refrain from unlawful activity at all times
- Participate in clinical outcome reviews, quality assurance procedures, and quality improvement programs
- Hold in the strictest confidence all information pertaining to peer review, quality assurance, and quality improvement
- Protect from loss or theft, and not share, log-ins and passwords to any hospital system that contains patient identifiable information or other confidential hospital information

Reporting:

Potential breaches of the Code of Professional Behavior by a practitioner will be dealt with in accordance with the Medical Staff Policies concerning Disruptive Conduct or Workplace Harassment. If there is a possibility of an impairment issue, the Physician Assistance Policy should be referenced and consideration be giving to referring the practitioner to the Medical Staff Physician Assistance Committee.

Medical Staff Code of Professional Behavior
Acknowledgement of Receipt

Each Medical and Allied Health Staff member has a responsibility for the welfare, well-being, and betterment of the patient being served. In addition, the practitioner has a responsibility to maintain his/her own professional and personal well-being, in addition to maintaining a reputation for truth and honesty.

I have received and reviewed the Medical Staff Code of Professional Behavior Policy for Memorial Hospital and Health System; I will use my best efforts to comply with the Policy on an on-going basis.

I have read, understand, and agree to abide by this Policy,

Signature: _____

Printed Name: _____

Date: _____

Please sign, date and return this acknowledgement page along with your application packet.

**PLEASE COMPLETE THE FOLLOWING PAGES IF
ENTERING INTO A CONTRACT WITH
MEMORIAL MEDICAL GROUP**

1. Memorial Health System Consent to Release Information
2. Electronic Signature Authorization

MEMORIAL HEALTH SYSTEM CONSENT TO RELEASE INFORMATION

I authorize Memorial Health System, Inc. and its authorized representatives to consult with any third party that may have any information bearing on my personal professional qualifications, credentials, clinical competence, character, mental and/or emotional stability, physical condition, ethics, behavior or any other matter they deem relevant, as well as inspect or obtain copies of any and all communications, reports, records, statements, documents, recommendations or disclosures prepared, developed or collected by said third parties. I authorize said third parties to release such information to Memorial Health System, Inc. and its authorized representatives upon request without authority. I also authorize Memorial Health System, Inc., to release the Pre-Application and all associated information and documents collected, developed or provided as part of the pre-application process to the verification organization contracted by Memorial Health System, Inc., for credentialing purposes, if any.

To the fullest extent permitted by law, I extend absolute immunity and release and hold harmless from any claim, demand, suit and all liability, Memorial Health System, Inc. and its authorized representatives, contracted verification organizations, if any, and any third party who provided materials to or discussed any disclosures involving me, performed, made, requested, or received by Memorial Health System, Inc. and its authorized representatives, from or by any such third party, including otherwise privileged or confidential information made or given in good faith.

I also certify that the information given in or attached to this application is accurate and fairly represents the surest level of my training, experience, capability, and competence to practice. I further understand that any misrepresentation, misstatement in, or omission of this application whether intentional or not, shall, of itself alone, constitute cause for automatic and immediate rejection of the application. In the event this application is approved prior to the discovery of such misrepresentation, misstatement or omissions, such discovery may, at Memorial Health System, Inc.'s sole discretion, result in termination of any agreement made as a result of this application by and between Memorial Health System, Inc. and myself.

I agree to promptly update this application while it is being processed should there be any change in the information provided. Failure to update this application with changed information may, at Memorial Health System, Inc.'s discretion, constitute cause for immediate rejection of this application or termination of any agreement.

Signature: _____ Date: _____

MEMORIAL HOSPITAL & HEALTH SYSTEM

ELECTRONIC SIGNATURE AUTHORIZATION

I, _____, give the authorization to the Managed Care Credentialing Representative to use my electronic signature for a one-year period of time in completing managed care applications that have been approved for participation by the MMG management committee. By doing so, I attest to the accuracy of the application, questions addressed in Attachment B and authorized release of all information for credentialing purposes to the managed care plans.

I, _____, agree to supply to the managed care credentialing representative the necessary information needed for credentialing as outlined in Attachment A.

I, _____, also agree to supply any information relating to Attachment A or B that may change directly to the managed care credentialing representative as it becomes applicable. ON a yearly basis, I will meet with the credentialing representative and go over all documentation and questions and a new Authorization will be completed.

Signature

Date

one year from signature date
Expiration