

**Standardized
Credentialing
Form
To Be Used
By Health Maintenance Organizations
Licensed in the State of Missouri**

REVISED VERSION EFFECTIVE FEBRUARY 2, 2001
COMPLETE EACH SECTION AS THOROUGHLY AS POSSIBLE. PLEASE TYPE OR PRINT

I. GENERAL INFORMATION

1. _____
Name (Last, First, MI, Degree/Prof. Designation
M.D./D.O./Ph.D./O.D./M.S.W./D.C./D.P.M./D.D.S./D.M.D./A.P.N./P.A./Other)

2. _____
Home Address/Street

3. _____ 4. _____
City/State/ZIP E-Mail Address

5. _____ 6. _____
Other Names You May Have Used (i.e. Maiden, etc.) Date of Birth (Month/Day/Year)

7. _____ 8. _____
Place of Birth Social Security Number

9. Are You a U.S. Citizen? Yes _____ No _____ 10. Sex: Male _____ Female _____

If Not a Citizen of the U.S., Indicate the Current Status of Your VISA:



Form Authorized by the Missouri Department of Insurance 1998
DO NOT SUBMIT COMPLETED FORM TO THE DEPARTMENT OF INSURANCE

II. OFFICE/PRACTICE INFORMATION

If More Than Two Offices, Check Here and Attach a Copy of Page 3, Completing Questions 22 - 40 for Each Office.

1. Participation Status For Which You Are Applying: (Indicate Specialty)

Primary Care: _____ Specialty: _____ Subspecialty: _____ Patient Ages: _____

2. **PRIMARY OFFICE** ADDRESS/STREET/BUILDING/SUITE _____ From: _____
(month/year)

3. City/State/ZIP _____

4. Tax ID # Owner/Corporate Name as Appears on SS4 or W-9 Form (or Full Legal Name) _____

5. Business Name or Name By Which the Provider Group is Generally Known _____

6. Office Phone Number _____ 7. After Hours/Emergency Number or Procedure _____

8. Office Fax Number _____ 9. Office E-Mail Address _____

10. Office Manager _____ 11. Federal Tax ID# _____

12. BILLING ADDRESS/STREET (if Different From Above) _____

13. Billing City/State/ZIP _____

14. List Routine Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday

15. Evening Hours: Yes No If Yes, List Hours After 5:00 P.M.

Monday	Tuesday	Wednesday	Thursday	Friday

16. Weekend Hours: Yes No

Saturday	Sunday

17(a) Lab Service in Your Office:
Yes No

17(b) _____
If Yes, specify Waived, Physician Performed Microscopy,
Moderately Complex, Highly Complex

18. Please check all of the following that you perform IN THIS OFFICE:

EKG Office gynecology (Routine Pelvic/PAP) Drawing Blood Age appropriate immunizations
X-Rays Minor Surgery Tympanometry/audiometry screening Flexible sigmoidoscopy
Laceration Repair Pulmonary Function Studies Asthma Treatment Allergy Skin Testing
Osteopathic manipulation IV hydration/treatment Other (please specify) _____

19. (a) Languages Spoken (other than English): _____ (b) Are Interpreters Available? Yes No

Health Care Provider _____ Staff _____

20. Does Your Office: (CIRCLE ONE)

(a) Have 24-Hr. Phone Coverage Service?	Y	N	(b) Qualify as a Minority Business Enterprise?	Y	N
(c) Have Capability for Electronic Billing?	Y	N	(d) Provide Child Care Services?	Y	N
(e) Meet ADA Accessibility Standards?	Y	N	(f) Have Public Transportation Accessibility?	Y	N
(g) Collaborate With an Advanced Nurse Practitioner or Physician Assistant (P.A.)?				Y	N

If Yes, Provide a Copy of Appropriate Collaborative Practice or P.A. Agreement(s) & the Name(s) of the Individual(s).

(h) Type of Practice: Solo Single Specialty Group Multispecialty Group Other
If Group Practice, Attach a List of Other Members of Your Practice, Their Specialties, and Coverage Arrangements.

21. Do You Currently: (CIRCLE ONE)

(a) Accept New Patients Into Practice?	Y	N	(b) Accept New Patients By Physician Referral Only?	Y	N
(c) Have Medicare Certification?	Y	N	(d) Accept Medicare Assignment?	Y	N
(e) Provide Inpatient Care?	Y	N	(f) Accept Medicaid Assignment?	Y	N



II. OFFICE/PRACTICE INFORMATION (cont'd)

Attach Additional Copies As Necessary.

22. **SECONDARY OFFICE** ADDRESS/STREET/BUILDING/SUITE _____

23. City/State/ZIP _____

24. Tax ID # Owner/Corporate Name as Appears on SS4 or W-9 Form (or Full Legal Name) _____

25. Business Name or Name By Which the Provider Group is Generally Known _____

26. Office Phone Number _____ 27. After Hours/Emergency Number or Procedure _____

28. Office Fax Number _____ 29. Office E-Mail Address _____

30. Office Manager _____ 31. Federal Tax ID# _____

32. BILLING ADDRESS/STREET (if Different From Above) _____

33. Billing City/State/ZIP _____

34. List Routine Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday

35. Evening Hours: Yes _____ No _____ If Yes, List Hours After 5:00 P.M.

Monday	Tuesday	Wednesday	Thursday	Friday

36. Weekend Hours: Yes _____ No _____

Saturday	Sunday

37.(a) Lab Service in Your Office:

Yes _____ No _____

37.(b)

If Yes, specify Waived, Physician Performed Microscopy, Moderately Complex, Highly Complex

38. Please check all of the following that you perform IN THIS OFFICE:

EKG _____ Office gynecology (Routine Pelvic/PAP) _____ Drawing Blood _____ Age appropriate immunizations _____
 X-Rays _____ Minor Surgery _____ Tympanometry/audiometry screening _____ Flexible sigmoidoscopy _____
 Laceration Repair _____ Pulmonary Function Studies _____ Asthma Treatment _____ Allergy Skin Testing _____
 Osteopathic manipulation _____ IV hydration/treatment _____ Other (please specify) _____

39. (a) Languages Spoken (other than English): _____

(b) Are Interpreters Available? Yes _____ No _____

Health Care Provider _____

Staff _____

40. Does Your Office: (CIRCLE ONE)

(a) Have 24-Hr. Phone Coverage Service?	Y	N	(b) Qualify as a Minority Business Enterprise?	Y	N
(c) Have Capability for Electronic Billing?	Y	N	(d) Provide Child Care Services?	Y	N
(e) Meet ADA Accessibility Standards?	Y	N	(f) Have Public Transportation Accessibility?	Y	N
(g) Collaborate With an Advanced Nurse Practitioner or Physician Assistant (P.A.)?	Y	N		Y	N

If Yes, Provide a Copy of Appropriate Collaborative Practice or P.A. Agreement(s) & the Name(s) of the Individual(s).

(h) Type of Practice: Solo Single Specialty Group Multispecialty Group Other _____
 If Group Practice, Attach a List of Other Members of Your Practice, Their Specialties, and Coverage Arrangements.

41. Do You Currently: (CIRCLE ONE)

(a) Accept New Patients Into Practice?	Y	N	(b) Accept New Patients By Physician Referral Only?	Y	N
(c) Have Medicare Certification?	Y	N	(d) Accept Medicare Assignment?	Y	N
(e) Provide Inpatient Care?	Y	N	(f) Accept Medicaid Assignment?	Y	N



III A. PROFESSIONAL EDUCATION

List All Medical Schools/Institutions Attended.

Please Explain Any 30 Day or Greater Gap In Your Training. Attach Additional Sheets if Necessary.

1. _____
Medical/Professional School Name
2. _____
Address/Street
3. _____
City/State/Zip/Country
4. From: _____ To: _____ 5. _____
Dates Attended (month/year) Degree(s) Awarded
6. If You Are a Graduate of a Foreign Medical School, Are You Certified by the Education Council for Foreign Medical Graduates (ECFMG)? If Yes, Please Enclose a Copy of Your Certificate With This Application.
Yes _____ No _____

III B. POSTGRADUATE TRAINING: INTERNSHIP

1. _____
Institution Name
2. _____
Address/Street
3. _____
City/State/Zip
4. From: _____ To: _____ 5. _____
Dates Attended (month/year) Department Chair/Program Director
6. _____
Type of Internship (Rotating/Straight) - If Straight, Please List Specialty.

III C. POSTGRADUATE TRAINING: FIRST RESIDENCY

1. _____
Institution Name
2. _____
Address/Street
3. _____
City/State/Zip
4. From: _____ To: _____ 5. _____
Dates Attended (month/year) Department Chair/Program Director
6. _____
Type of Residency

III D. POSTGRADUATE TRAINING: SECOND RESIDENCY or FELLOWSHIP

1. _____
Institution Name
2. _____
Address/Street
3. _____
City/State/Zip
4. From: _____ To: _____ 5. _____
Dates Attended (month/year) Department Chair/Program Director
6. _____
Type of Residency/Fellowship



III E. POSTGRADUATE TRAINING: FELLOWSHIP/OTHER

1. _____
Institution Name

2. _____
Address/Street

3. _____
City/State/Zip

4. From: _____ To: _____
Dates Attended (month/year)

5. _____
Department Chair/Program Director

6. _____
Type of Fellowship/Other Explanation

IV A. HOSPITAL AFFILIATIONS: PRIMARY

1. _____
CURRENT PRIMARY HOSPITAL NAME

2. _____
Address/Street

3. _____
City/State/Zip

4. _____
Status of Privileges (INDICATE BY USING KEY)

5. From: _____ To: _____
Dates Affiliated (month/year)

Status of Privileges Key

1 Active	4 Associate	7 Courtesy	10 Senior Staff	13 Consulting
2 Courtesy Provisional Staff	5 Visiting	8 Admitting	11 Provisional	14 Pending
3 Active Provisional Staff	6 Temporary	9 CO-Admitting	12 Suspended	15 Other: _____

If CO-Admitting Status, List Other Admitting Physician(s) _____

6. Any Past or Present Restriction of Privileges? Yes _____ No _____ (IF YES, EXPLAIN)

IV B. HOSPITAL AFFILIATIONS: OTHER

List All Other Hospitals At Which You Have Or Have Had Privileges. Attach Additional Pages If Necessary.

1a. _____
HOSPITAL NAME

2a. _____
Address/Street

3a. _____
City/State/Zip

4a. _____
Status of Privileges (INDICATE BY USING KEY)

5a. From: _____ To: _____
Dates Affiliated (month/year)

If CO-Admitting Status, List Other Admitting Physician(s) _____

6a. Any Past or Present Restriction of Privileges? Yes _____ No _____ (IF YES, EXPLAIN)

1b. _____
HOSPITAL NAME

2b. _____
Address/Street

3b. _____
City/State/Zip

4b. _____
Status of Privileges (INDICATE BY USING KEY)

5b. From: _____ To: _____
Dates Affiliated (month/year)

If CO-Admitting Status, List Other Admitting Physician(s) _____

6b. Any Past or Present Restriction of Privileges? Yes _____ No _____ (IF YES, EXPLAIN)



IV B. HOSPITAL AFFILIATIONS: OTHER (CONT'D)

1c. _____
HOSPITAL NAME

2c. _____
Address/Street

3c. _____
City/State/Zip

4c. _____ 5c. From: _____ To: _____
Status of Privileges (INDICATE BY USING KEY) Dates Affiliated (month/year)
If CO-Admitting Status, List Other Admitting Physician(s)

6c. Any Past or Present Restriction of Privileges? Yes _____ No _____ (IF YES, EXPLAIN)

IV C. OTHER PRACTICE AFFILIATIONS (e.g. HMOs, PPOs, IPAs, PHOs, etc.)

Attach Additional Pages If Necessary

1a. _____
Institution/Organization Name

2a. _____
Address/Street

3a. _____
City/State/Zip

4a. _____ 5a. From: _____ To: _____
Type of Affiliation Dates Affiliated (month/year)

1b. _____
Institution/Organization Name

2b. _____
Address/Street

3b. _____
City/State/Zip

4b. _____ 5b. From: _____ To: _____
Type of Affiliation Dates Affiliated (month/year)

1c. _____
Institution/Organization Name

2c. _____
Address/Street

3c. _____
City/State/Zip

4c. _____ 5c. From: _____ To: _____
Type of Affiliation Dates Affiliated (month/year)

1d. _____
Institution/Organization Name

2d. _____
Address/Street

3d. _____
City/State/Zip

4d. _____ 5d. From: _____ To: _____
Type of Affiliation Dates Affiliated (month/year)

1e. _____
Institution/Organization Name

2e. _____
Address/Street

3e. _____
City/State/Zip

4e. _____ 5e. From: _____ To: _____
Type of Affiliation Dates Affiliated (month/year)



VII. PROFESSIONAL CERTIFICATES / LICENSE NUMBERS

List All States In Which You Have Held, or Currently Hold a License to Practice Your Profession. Please Attach Copies.

1. _____ License/Certification/Registration Number; Licensing State	2. _____ Expiration Date
3. _____ Other License/Certification/Registration Number; Licensing State	4. _____ Expiration Date
5. _____ Other License/Certification/Registration Number; Licensing State	6. _____ Expiration Date
7. _____ Federal Drug Enforcement Agency (DEA) Number(s)	8. _____ Expiration Date(s)
9. _____ CDS Certification Number (BNDD Number for Missouri)	10. _____ Expiration Date
11. _____ Medicare/Unique Provide ID Number (UPIN)	12. _____ National Provider ID Number (NPI)
13. _____ State Medicaid Number(s); Licensing State(s)	14. _____ ECFMG Number

VIII. PROFESSIONAL LIABILITY INSURANCE INFORMATION

Please Attach a Copy of Your Current Certificate(s) or Declaration(s) of Insurance, Including HCSF for Kansas Practitioners.

1a. _____
CURRENT CARRIER NAME

2a. _____
Address/Street

3a. _____
City/State/Zip

4a. _____
Phone Number

5a. _____
Policy Number

6a. From: _____ To _____
Dates of Coverage (month/year)

7. Indicate Coverage Type: Claims Based _____ Occurrence Based _____

8. Policy Limits: Per Occurrence \$ _____ Aggregate \$ _____

Prior Carriers Within the Last Ten (10) Years. Attach Additional Sheets if Necessary.

1b. _____
PREVIOUS CARRIER NAME

2b. _____
Address/Street

3b. _____
City/State/Zip

4b. _____
Phone Number

5b. _____
Policy Number

6b. From: _____ To _____
Dates of Coverage (month/year)

1c. _____
PREVIOUS CARRIER NAME

2c. _____
Address/Street

3c. _____
City/State/Zip

4c. _____
Phone Number

5c. _____
Policy Number

6c. From: _____ To _____
Dates of Coverage (month/year)

1d. _____
PREVIOUS CARRIER NAME

2d. _____
Address/Street

3d. _____
City/State/Zip

4d. _____
Phone Number

5d. _____
Policy Number

6d. From: _____ To _____
Dates of Coverage (month/year)



IX. MALPRACTICE CLAIMS HISTORY

***A SIGNATURE IS REQUIRED AT THE BOTTOM OF THIS PAGE, EVEN IF THERE IS NO HISTORY TO REPORT**

Are you currently or have you within the last ten (10) years been involved in a malpractice suit or other suit or claim in which your care and treatment of a patient was at issue, including pending or dismissed cases or claims settled before or during trial, or settled to avoid a lawsuit? Yes ___ No ___

If yes, answer the following questions for EACH such claim. Duplicate this page as necessary.

- 1. _____ Patient Name
- 2. _____ Plaintiff Name, If Other Than Patient
- 3. _____ Your Involvement in the Case (Attending, Consulting, Etc.)
- 4. _____ Date of Occurrence (month/day/year)
- 5. _____ Your Status in the Case (Primary Defendant, Co-Defendant, Other)
- 6. _____ Date Claim Was Filed (month/day/year)
- 7. _____ Professional Liability Insurance Carrier Involved
- 8. _____ Carrier's Phone Number
- 9. _____ Policy Number
- 10. _____ Additional Defendants
- 11. Describe the Allegations Against You:

- 12. Describe the Alleged Injury to the Patient:

- 13. Claimant/Plaintiff Filed Suit in Court? Yes _____ No _____
- 14. _____ State Court Case Number
- 15. _____ State
- 16. _____ County/Parish
- 17. _____ Federal Court (US District Court) Case Number
- 18. _____ District
- 19. Present Status of Claim: Open _____ Closed _____ Pending _____

If PENDING, DO NOT Complete the Rest of This Page **Except For Signature and Date**.

- 20. If Closed, Indicate the Method of Resolution:

Dismissed _____	Date: _____
Settled (With Prejudice) _____	Date: _____
Settled (Without Prejudice) _____	Date: _____
Judgment for Defendant(s) _____	Date: _____
Judgment for Plaintiff(s) _____	Date: _____
Other _____	Date: _____
- 21. _____ Settlement Amount Paid On Your Behalf (If Any)
- 22. Additional Information/Explanation:
(e.g. Patient condition and diagnosis at time of incident, description of treatment, subsequent patient outcome, etc.)

Signature _____

Date (month/day/year) _____

IF YOU HAVE NO HISTORY TO REPORT, PLEASE INDICATE THAT AND SIGN.



X. ADDITIONAL INFORMATION

Please Answer the Following Questions By Circling "Y" (Yes), "N" (No), or "N/A" (Not Applicable).

Please Provide an Explanation For Any "Yes" Responses on a Separate Page.

1. Have any of your board certifications ever been suspended, revoked, not renewed, denied renewal, voluntarily or involuntarily surrendered?	Y	N	N/A
2. Have you ever been named as a defendant in any criminal case?	Y	N	N/A
3. Have you ever been convicted, pled guilty, or pled nolo contendere to any felony, any offense reasonably related to your qualifications, functions, or duties as a medical professional, or any offense an essential element of which is fraud, dishonesty, or an act of violence?	Y	N	N/A
4. Has your malpractice insurance ever been canceled, suspended, not renewed, special rated, or restricted by the exclusion of any specific procedures from coverage?	Y	N	N/A
5. Have you ever been denied participation, suspended from, or denied renewal from the Medicare or Medicaid program, or had participation status modified?	Y	N	N/A
6. Has your authority to practice in any state been suspended, revoked, voluntarily or involuntarily surrendered, been subject to a consent or stipulation order, not renewed, denied renewal, or has probation ever been invoked?	Y	N	N/A
7. Has your federal or state controlled substance license ever been suspended, revoked, voluntarily or involuntarily surrendered, restricted, not renewed, denied renewal, or has probation ever been invoked?	Y	N	N/A
8. Have your privileges at any hospital or other health care setting ever been suspended, revoked, voluntarily or involuntarily surrendered, reduced, restricted, not renewed, denied renewal, or has probation ever been invoked?	Y	N	N/A
9. Within the last five years, have you ever been a participating provider of another HMO, PPO, PHO, or MSO, etc. with which you are not affiliated at this time?	Y	N	N/A
10. Have you ever received sanctions from a regulatory agency (e.g., CLIA, OSHA, etc.)?	Y	N	N/A
11. Has any information on you ever been reported to the National Practitioner Data Bank?	Y	N	N/A
12. Are you currently engaged in the illegal use of drugs? ("Illegal use of drugs" means the use of controlled substances obtained illegally, as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed health care practitioner. "Currently" does not mean on the day of or even the weeks preceding the completion of this application. Rather, it means recently enough so that the illegal use may have an impact on one's ability to practice.)	Y	N	N/A
13. Within the last five years, have you ever been reprimanded or disciplined in any manner by any state licensing authority or other professional board or peer review committee for conduct related to the use of alcohol or the use of any drug?	Y	N	N/A
14. Have you discontinued practice for any reason (other than for routine vacation) for one month (30 days) or more?	Y	N	N/A



X. ADDITIONAL INFORMATION (continued)

15. Do you or a member of your family own, have an investment in, or otherwise have a business interest in any clinical laboratory, diagnostic testing center, hospital ambulatory surgery center, or other business dealing with the provision of ancillary health services, equipment, or supplies?

Y N N/A

If so, please provide the following information, attaching additional copies as necessary.

(a) _____ Organization Name	(b) _____ Type of Organization
(c) _____ Address/Street	
(d) _____ City/State/Zip	
(e) _____ Phone Number	(f) _____ Federal Tax ID#
(g) _____ Percent of Business Owned/Invested by Applicant	(h) _____ Nature of Business Interest (owner, partner, investor)

XI. ADDITIONAL DOCUMENTATION / ATTACHMENTS

Please Attach Copies of the Following Documents (If Applicable):

1. W9 Form For Each Entity the Applicant Expects Will Receive Payments or Reimbursements.
2. Collaborative Practice and/or Physician Assistant Verification of Supervision Agreement(s).
3. A List of Other Members of Your Practice, Their Specialties, and Coverage Arrangements.
4. Education Council for Foreign Medical Graduates (ECFMG) Certificate.
5. Board Certification Certificate(s).
6. Copies of Professional Diplomas, Internship, Residency, and Fellowship Certificates, As Applicable.
7. Current State Licenses (For All States Practicing).
8. Federal DEA Certificate.
9. State Controlled Substance Certificate(s) For All States Practicing (i.e. BNDD for Missouri).
10. Current Certificate(s) or Declaration(s) of Insurance, Including HCSF for Kansas Practitioners.
11. Curriculum Vitae (If Required By Health Carrier)
12. Professional References (If Required By Health Carrier)
13. Signed Copy of an Affirmation and Release of Information Document (Attestation Page) As Stipulated By the Health Carrier to Which the Applicant is Seeking to Become a Participating Provider.
14. Attach a copy of all postgraduate (CME) activities which you have attended and for which you have received credit in the past 2 years.
15. Include a list of societies of which you are currently a member.
16. Include copies of United States Military discharge papers/DD214 if discharged from U.S. Military, or status if currently serving.
17. Include a copy of certificate showing CLIA waiver number and identification number.
18. Provide a statement regarding the reasons for any inability to perform the essential functions, with or without accommodations, for the practice in which you are seeking to become a participating provider.



PROFESSIONAL REFERENCES

Please list five professional peers with the same type of license or a higher level of licensure who are familiar with your professional performance in the past three (3) years.

Name and Title: _____ **Specialty:** _____

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Facsimile: _____

Name and Title: _____ **Specialty:** _____

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Facsimile: _____

Name and Title: _____ **Specialty:** _____

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Facsimile: _____

Name and Title: _____

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Facsimile: _____

Name and Title: _____

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Facsimile: _____

APPLICANT'S ATTESTATION

I, _____, certify that the information I have provided and the statements I have made on this application are correct, true, and complete to the best of my knowledge. I will abide by the applicable bylaws, rules and regulations, and policies and procedures of the designated health care entity. I acknowledge that I have received and reviewed a copy of the bylaws, if applicable, of the designated health care entity. I further agree that, in the event there should arise an adverse ruling with respect to my status and/or clinical privileges, I will exhaust the administrative remedies afforded by the entity's bylaws before resorting to litigation.

Signature stamps and date stamps are not acceptable.

Signature

Date (do not type)

All applicants have the right to be informed of their application status. Application status inquiries should be directed to the appropriate health care organization. Practitioners may utilize any or all of the following to ensure accurate file information.

- **The right of practitioners to review information submitted to support their credentialing application.**
- **The right of practitioners to correct erroneous information.**
- **The right of practitioners to be informed of the status of their credentialing or recredentialing application upon request.**
- **The right of practitioners to be notified of these rights.**

This application has been designed to streamline the credentials verification process for providers, and meets the standards of many accrediting organizations. The application will be processed in accordance with the customer's required standards.

Hospital Services Corporation, a subsidiary of the New Mexico Hospital Association, maintains this form. If you have any questions about this form, please contact one of our credentials analysts at (505) 343-0070 or toll-free (866) 908-0070, or by e-mail at cvs@nmhsc.com. This application has been copyrighted and is intended for the sole use of our customers and approved users.

**HOSPITAL SERVICES CORPORATION
CREDENTIALS VERIFICATION SERVICE
DESIGNATION AND AUTHORIZATION FOR RELEASE AND REDISCLOSURE OF INFORMATION
("Release")**

Authority to Release: I have applied to participate as a provider for _____

Print the names of all organizations to which you are applying.

and its authorized representatives (hereafter "Health Care Entity") which has designated Hospital Services Corporation's Credentials Verification Service ("HSC") as their agent. I consent to complete disclosure by the recipient of this release to HSC of all relevant information pertaining to my professional qualifications, moral character, physical and mental health (hereinafter "qualifications"). I authorize the recipient to make available and/or disclose to HSC all such information in its files from any university, professional school, licensing authority, accreditation board, hospital, physician, dentist, professional society, insurance carrier, law enforcement agency, military service, or any other person or entity deemed necessary or appropriate in the investigation and processing of my application.

I request and authorize the recipient to release the requested information and I expressly waive any claim of privilege or privacy with respect to the released information bearing on my admission to, retention or termination of medical staff appointment or clinical privileges. I release and discharge HSC, the Health Care Entity and the medical, dental, podiatry and ancillary staffs or panels, credentials committees, administrators, review and approval boards or committees, governing boards, whether or not designated by these titles, and their agents, servants or employees authorized by representatives and all other persons or entities supplying information to them from liability or claims of any kind or character in any way arising out of inquiries concerning me or disclosures made in good faith in connection with my application for appointment to the Health Care Entity's Medical Staff or Provider Panel.

Authority to Redisclose: Unless I have denied authority by initialing here _____, I authorize the Health Care Entity, the Health Care Entity's Authorized Representatives, and HSC to redisclose information concerning my qualifications, or credentials and privileges to third parties who have a need to know the information (1) based upon state or federal laws or regulations, or (2) pursuant to any health care provider agreement to which I am or will be a party and in which I have an interest as an individual health care provider, or (3) to participate in the common recredentials program, if applicable.

This Release does not authorize HSC to disclose information about my qualifications to any claimant. If a claimant requests information from HSC about me or if a subpoena duces tecum is served upon HSC seeking information about me, which is in HSC's possession, I understand I will be notified immediately. If I direct HSC to resist the subpoena, I hereby agree to indemnify and hold harmless HSC, its officers, directors, employees and agents for all attorney fees, costs, fines, and expenses incurred in resisting the subpoena at my request.

This authorization is limited to the acquisition and disclosure of information required by state or federal law, and information which is acquired or disclosed pursuant to activities protected by the state's Review Organizational Immunity Act and the Health Care Quality Improvement Act of 1986. A photocopy of this Designation and Authorization for release and redisclosure of information shall be considered by the recipient to be a signed original, as long as it is transmitted to the recipient by HSC and is received within five years of its date.

The certain definitions used in this Release and set forth on the following page of this application are incorporated by reference. I understand that I may withdraw or modify this authorization at any time in writing by submitting a written request to HSC. PHOTOCOPY BOTH PAGES OF THIS FORM.

Signature stamps and date stamps are not acceptable.

Applicant Signature

Printed Name

Date (do not type)