Applicant:

Statement of Understanding, Attestation and Consent & Release from Liability

In signing the application for Medical Staff Appointment,

I understand and authorize the staff of IFHS to release acquired information to State Licensing Boards or Agencies of the Federal Government, or other similar entities at the discretion of IFHS.

I release from liability all those that provide information to IFHS in good faith and without malice, in response to their inquiries.

I certify that the answers to the foregoing questions are true to the best of my knowledge, and that the statements I have made in connection with this application, interview, and my CV/resume are also true. I have not omitted anything, which might be important to the facility I am requesting grant me clinical privileges and medical staff.

I understand that any misstatements in, or omissions from this application may constitute cause for summary revocation of my appointment and privileges and termination of my employment. All information submitted by me on this application is true and correct to the best of my knowledge and belief.

I authorize IFHS and/or its agents, its medical staff and/or their representatives to consult with other persons, hospitals, associations, institutions, and malpractice carriers that I have been associated with to ascertain information which may be pertinent to my application, including, but not limited to:

> professional education, training and experience
> clinical competence
> malpractice history
> military and police records
> ethical qualifications
> medical records as they pertain to Quality Assurance
> records and documents, including medical records at other hospitals as they pertain to Quality Assurance
> OIG/GSA Reports
> My Health Status as it pertains to my ability to practice safely

I hereby release from liability all representatives of IFHS and its professional staff for all acts performed in good faith and without malice in connection with evaluating my application, credentials, and professional qualification. I am willing to appear in person to discuss any matters related to this application.

Notice to Providers: 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 patients 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.

Photocopies and/or facsimile copies of this Authorization will serve the same purpose as the originally executed document.

Signature_____ Date: _____
(Stamped or representative signatures unacceptable)

Printed Name: _____