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| **Figure 3.10** | **Applicant Attestation, Consent, and Release From Liability** |
| By signing this form, I:  » Attest to the accuracy and completeness of all information on the application and accompanying doc- uments and agree that any inaccuracy, omission, or misrepresentation, whether intentional or not, may be grounds for termination of the application process without the right to a fair hearing or appeal. If the  inaccuracy, omission, or misstatement is discovered after I have been granted appointment and/or clinical privileges, my appointment and/or privileges shall lapse effective immediately upon notification, without the right to a fair hearing or appeal.  » Attest that I have read and agree to abide by the Expectations of Practitioners Granted Privileges.  » Attest that I have read and agree to abide by the requirements for patient rights and restraint administration.  » Consent to appear for any requested interviews in regard to the application.  » Authorize the hospital and medical staff representatives to consult with prior and current associates and others who may have information bearing on my professional competence, character, ability to perform  the privileges requested, ethical qualifications, ability to work cooperatively with others, and other qualifi- cations for membership and the clinical privileges requested.  » Authorize administrative representatives to copy my application and other documents as needed for the purpose of insurance reimbursement. This does not include any peer information in my credentials file.  » Consent to [Hospital] and medical staff representatives’ inspection of all records and documents, includ- ing but not limited to procedure and/or case logs, volume data, and quality data from any and all current  and former affiliates that may be material to an evaluation of:  › Professional qualifications and competence to carry out the clinical privileges requested  › Physical and mental/emotional health status to the extent relevant to safely perform requested privileges  › Professional and ethical qualifications  › Professional liability actions including currently pending claims involving the applicant  › Any other issue relevant to establishing the applicant’s suitability for membership and/or privileges  » Release from liability, promise not to sue, and grant immunity to the hospital, its medical staff, and its rep- resentatives for acts performed and statements made in connection with evaluation of the application and my credentials and qualifications to the fullest extent permitted by the law.  » Release from liability and promise not to sue all individuals and organizations who provide information to the hospital or the medical staff, including otherwise privileged or confidential information to hospital representatives concerning my background, experience, competence, professional ethics, character, physical and mental health to the extent relevant to the capacity to fulfill requested privileges, emotional stability, utilization practice patterns, and other qualifications for staff appointment and clinical privileges. | |

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| **Figure 3.10** | **Applicant Attestation, Consent, and Release From Liability (cont.)** |
| » Authorize the medical staff and administrative representatives to release information to other hospitals, medical associations, licensing boards, and other healthcare entities concerned with my performance and release representatives of [Hospital] from liability for so doing.  » Acknowledge I have had access to the medical staff bylaws, including all rules, regulations, policies, and procedures of the medical staff and agree to abide by their provisions.  » Agree to provide accurate answers to the questions asked on the application form and to notify, within 10 business days, the medical staff services department of [Hospital] in writing should any of the information  regarding these items change during the application process or during the period of my medical staff membership or privileges. I understand that if I answer any of the questions on the application affirma- tively, or if a problem is identified, I will be required to submit a written explanation of the circumstances involved.  » Acknowledge that I have been educated about the hospital’s mechanism for reporting concerns about the safety or quality of care in this organization, including but not limited to the physician hotline.  » Acknowledge that I have been informed of my right to report concerns about the safety or quality of care provided in the organization to The Joint Commission. I also acknowledge that I have been informed that  the organization will take no disciplinary action against me for sharing concerns with The Joint Commis- sion. Finally, I acknowledge and agree that I will not abuse this right by knowingly and willfully providing a false report to The Joint Commission regarding safety and/or quality of care rendered by the organization.    Applicant signature Date  Typed/printed name | |