Anderson Hospital
6800 State Route 162
Maryville, Illinois 62062
618-391-6140 ◆ 618-391-6141
618-288-2164 FAX
MSO@AndersonHospital.org

ATTESTATION

I hereby apply for medical staff appointment and clinical privileges as requested in this application. I am willing to make myself available for interviews in regard to this application.

As a applicant, I have the burden of producing adequate information for proper evaluation of this Application. I agree to provide Anderson Hospital with updated current information regarding all questions on this application as such information becomes available and such additional information as may be requested by Anderson Hospital or its Authorized Representatives.

I represent that the information given in or attached to this application is accurate and fairly represents that current level of my training, experience, capability and competence to practice.

I REALIZE AND AGREE THAT ANY MISREPRESENTATION, SIGNIFICANT MISSTATEMENT OR OMISSION IN THIS APPLICATION SHALL CONSTITUTE GROUNDS FOR DENIAL OF APPOINTMENT OR TERMINATION OF ANY CLINICAL PRIVILEGES GRANTED.

I understand that this application will be considered in accordance with the By-laws, Rules and Regulations of the Medical Staff of Anderson Hospital, and agree to be bound by those By-laws, Rules and Regulations. I understand that I have the burden of establishing my eligibility and competence.

By applying for appointment and clinical privileges, I accept that I have the responsibility to keep this application current by informing the hospital, through the Chief Executive Officer or his designee. I understand I am obligated to notify the hospital, through the Chief Executive Officer or his designee, immediately for professional license revocation, federal Drug Enforcement Agency license revocation, or any lapse in professional liability coverage. I further understand I must notify the hospital, as noted above, within in 5 days of any corrections, updates, and modifications for Medicare or Medicaid sanctions, revocation of any hospital privileges, or conviction of a felony, and within 45 days for any other change in information from the date the health care professional knew of the change. All updates should be made on the Healthcare Professional Data Gathering form, which is mandated by the state of Illinois.

I have received and had an opportunity to read a copy of Article IX of the By-Laws, Southwestern Illinois Health Facilities, Inc., and the Medical Staff By-Laws and I will receive a copy of policies upon my appointment. I specifically agree to abide by all such By-Laws, policies, directives, Rules and Regulations as are in force during the time I am appointed to the Medical Staff or exercise clinical privileges at Anderson Hospital.

I agree to abide by all of the ethical principles established by the national association of my profession. I agree not to receive from or pay to any other physician, either directly or indirectly, any part of any fee paid for professional services. I agree to provide continuous care and supervision for all of my patients at Anderson Hospital.

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Date Applicant's Signature

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Applicant's Printed Name