Anderson Hospital

Medical Staff Office
6800 State Route 162
Maryville, Illinois 62062
MSO@AndersonHospital.org

TO: _____

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_____

_____

The Medical Staff of Anderson Hospital, Maryville, Illinois requires each Medical Staff appointee and applicant to provide evidence of medical professional liability insurance coverage in the exact amounts of coverage per occurrence and per annual aggregate.

Please send a Certificate of Medical Liability Insurance or other documentation to Anderson Hospital verifying the class of my insurance, the exact limits of the coverage I have with your company, and claims history. I also authorize Anderson Hospital to verify specific privileges covered under my policy as well as any limitations of my coverage. If available, we have attached a copy of the policy for your convenience. **Please identify Anderson Hospital as the certificate holder on my policy.**

_____ _____

Signature Date

_____

Printed Name

_____

Office Address City State Zip

_____

Home Address City State Zip

SEND DIRECTLY TO YOUR MALPRACTICE INSURANCE CARRIER

STATEMENT OF AUTHORIZATION AND RELEASE
FROM LIABILITY TO MEDICAL LIABILITY PROVIDER

(Name and address of Insurance Entity)

_____

_____

_____ **Re: Policy#**_____

I, _____, am applying for appointment to the Medical Staff of Anderson Hospital and hereby authorize my carrier to release to the hospital all information regarding my claims history occurring from ******* **to present**, but not necessarily limited to:

1. Judgments entered
2. Claims settled, and
3. Cases and lawsuits pending

Please return this information to Anderson Hospital
6800 State Route 162, Maryville, IL 62062.
ATTENTION: Medical Staff Services, or FAX to (618) 288-2164
EMAIL: mersingerb@andersonhospital.org

In authorizing the release of such information to the hospital, I hereby release you from liability and indemnify you for acts performed in good faith and without malice in connection with supplying of this information needed for the processing my application for reappointment to Anderson Hospital Medical Staff.

_____ _____
Provider Signature Date