Anderson Healthcare

ATTESTATION

I hereby apply for appointment or reappointment and clinical privileges as requested in this application. I am willing to make myself available for interviews in regard to this application and that I will respond to requests for additional information within 15 days from the date of such request. I understand and acknowledge that the failure to produce any requested information will prevent my application from further consideration.

By applying for appointment or reappointment, I acknowledge that I have the burden of producing accurate and complete information for proper evaluation of this application and qualifications for membership and clinical privileges and for resolving any questions concerning my application and qualifications. I agree to provide Anderson Healthcare with updated current information regarding all questions on this application as such information becomes available and such additional information as may be required by Anderson Healthcare or its Authorized Representatives.

I represent that the information given in or attached to this application is accurate and fairly represents the current level of my training, experience, capabilities and competence to practice with the clinical privileges requested and acknowledge that such information will be used as a basis for evaluation of my request for appointment or reappointment. Further, I affirm that I am physically and mentally able to perform the clinical privileges requested and agree to report any changes in my physical and mental health that may alter my ability to render patient care.

I FULLY UNDERSTAND AND ACKNOWLEDGE THAT ANY MISREPRESENTATION, SIGNIFICANT MISSTATEMENT OR OMISSION FROM MY APPLICATION OR FAILURE TO TIMELY SUPPLEMENT OR AMEND THE APPLICATION, WHETHER INTENTIONAL OR NOT, SHALL CONSTITUTE GROUNDS FOR DENIAL OF APPOINTMENT OR REAPPOINTMENT OR TERMINATION OF ANY CLINICAL PRIVILEGES GRANTED.

I understand that this application will be considered in accordance with the Bylaws, Rules and Regulations of the Medical Staff of the Anderson Healthcare Entity/Entities to which I am applying and I agree to be bound by those Bylaws, Rules and Regulations. I understand that I have the burden of establishing my eligibility and competence.

By applying for appointment or reappointment and clinical privileges, I accept that I have the responsibility to keep this application current by informing the Authorized Anderson Healthcare Entity/Entities representative. I understand I am obligated to notify the Authorized Anderson Healthcare Entity/Entities representative 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 Authorized Anderson Healthcare Entity/Entities representative within five (5) days of any correction, 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 Health Care Professional Data Gathering Form, which is mandated by the State of Illinois.

I have had an opportunity to read a copy of the Anderson Healthcare Entity/Entities Medical Staff Bylaws. I specifically agree to abide by such Bylaws, policies, directives, Rules and Regulations affecting the Medical Staff as now written and as may be communicated to me from time to time.

I agree to abide by all of the ethical principles as defined in Federal and State and as established by the national association of my profession. I agree not to receive from or pay to another 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 while receiving care and demonstrate my professional competence and continued eligibility for Medical Staff membership at all Anderson Healthcare

Entity/Entities to which I am affiliated. I agree to practice only those clinical privileges granted by the Entity/Entities and for which I have professional insurance coverage. I agree to complete and sign all medical records and reports in accordance with the time schedules stated in the Bylaws, Rules and Regulations and understand that my Medical Staff privileges are subject to suspension and/or revocation if I fail to comply.

I acknowledge that appointment and privileges to practice within an Anderson Healthcare Entity/Entities is not a right of any individual who submits and application for appointment or reappointment. I understand that my request will be evaluated in accordance with the prescribed procedures state in the Entity/Facilities' and Medical Staff Bylaws, Rules and Regulations. I acknowledge that Anderson Healthcare has the right to determine the medical needs and to select Medical Staff based on those needs. In furtherance of the organizations activity to promote the quality of care provided to its patients, I release Anderson Healthcare and its representatives from civil liability for actions taken in good faith to evaluate and monitor the quality and use of the health care services that I render for purpose of my membership or exercised of clinical privileges, including any focused or ongoing professional practice evaluation (described below).

In providing care to patients, the Anderson Healthcare Entity/Entities may share certain information that you provide in your application within the organization and with its affiliated organizations for the purposes of treatment, payment and health care operations. For example, the Entity/Entities may share information to bill for its services, develop quality initiatives or enable communication to your office regarding your patients. In applying for Medical Staff membership, you acknowledge and consent to the use of this information by the Hospital.

I understand that, if appointed, the Anderson Healthcare Entity/Entities may conduct a focused or other review for a period of time as defined by the Entity/Facilities' Medical Staff Bylaws or as stated in my appointment notification. Further, I understand that in considering any advancement from this initial review period or for my continued membership on the Medical Staff, the Entity/Entities may conduct an ongoing professional practice evaluation and may begin a focused evaluation to assess professional competence, clinical quality or other aspects of care and participation in the Medical Staff process. **To permit this review, I authorize the Anderson Healthcare Entity/Entities to inspect and obtain copies of all records and documents that may be material to evaluating my professional/ethical qualifications, competence, standards, practice patterns or other matters relating to such evaluation and agree that the *Consent to Release* form signed and submitted with my Medical Staff application include such focused and/or ongoing professional practice evaluations.**

A photocopy of this **Attestation** is effective as the original document and may be relied upon by Anderson Healthcare and its representatives and employees for the above purposes.

Provider's Signature

Date

Printed Name