AUTHORIZATION, ATTESTATION, AND RELEASE

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

In making application for appointment to OCSHCN, I agree to abide by its medical staff's bylaws, rules and policies, to conduct my practice in accordance with high ethical traditions, and I pledge to provide continuous care for all my patients.

By applying for appointment to OCSHCN, I hereby signify my willingness to appear for interviews in regard to my application. I hereby authorize employees and agents of OCSHCN, and its medical staff, to consult with administrators and members of medical staffs of other hospitals or institutions with which I have been associated and with others including past and present malpractice carriers, provider networks, and educational institutions who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by employees and agents of OCSHCN and its medical staff of all documents that may be material to an evaluation of my professional qualifications for staff membership or clinical privileges.

I hereby release from liability all agents and employees of OCSHCN, and their medical staffs and representatives, for their acts performed in good faith and without malice in connection with obtaining information to consider my application, credentials, and qualifications and the evaluation thereof.

I hereby further authorize OCSHCN to communicate to other entities with a legitimate interest therein, any information concerning my professional competence, character, ethics, and other qualifications that OCSHCN may acquire. If communication is made in good faith and without malice, I consent thereto and agree to hold OCSHCN, their employees and agents, and their medical staffs and their agents, free of liability thereof.

I understand and agree that I, as an applicant for appointment, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubts about those qualifications.

I hereby further release from liability any and all individuals, organizations and institutions that provide information concerning my professional competence, character, ethics and other qualifications, to OCSHCN and its medical staff, if the information is provided in good faith and without malice.

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I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I acknowledge that OCSHCN will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration, cause for denial of appointment or cause for summary dismissal from OCSHCN.

I understand and agree that a facsimile or photocopy of this Authorization, Attestation, and Release shall be as effective as the original.

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Printed Name

____ ________________

Signature Date