



# PHS

Always Here For You

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## Pima Health System

3950 South Country Club Road, Suite 400 \* Tucson, Arizona 85714 \* (520) 243-8000

### Instructions for Completing the Initial Application

- Complete all areas on the application
- Do not leave any blanks
- Incomplete applications WILL be returned
- Print completed application, sign pages 12 and 13
- Send with readable copies of:
  - o Arizona professional license
  - o DEA certificates
  - o Malpractice insurance certificate
  - o Degree(s) or education certificates and post graduate training certificates
  - o Military release certificate (DD214), if applicable
  - o Board certification (certificate, status letter)
  - o Current curriculum vitae to include from Degree forward
  - o One current photo
- Completed application must be returned to GACCP within 6 weeks of receipt of the request.
- If complete application is not received by GACCP within 6 weeks your request will be withdrawn automatically.

#### PIMA HEALTH CARE SYSTEM AFFILIATES

Department of Institutional Health • Pima Health System/Pima Health Plan & Pima Long Term Care • Community Services System  
Posada del Sol Health Care Center • Pima County Health Department

# GREATER ARIZONA CENTRAL CREDENTIALING PROGRAM



326 EAST CORONADO ROAD  
PHOENIX, ARIZONA 85004-1576  
TELEPHONE: 602-256-0705  
FAX: 602-256-2763

MARICOPA  
COUNTY  
MEDICAL  
SOCIETY

## INITIAL APPLICATION FOR MEDICAL STAFF OR HEALTH CARE ENTITY

Date
APPLICATION SENT: _____
APPLICATION RECEIVED: _____
VERIFICATION COMPLETED: _____

Application will be returned if not complete.

Incomplete addresses will delay file.

DO NOT leave any blank spaces. "See CV" is not acceptable, if not applicable mark N/A.

Please PRINT (using black ink) or type. \*If using a Highlighter, use yellow ONLY

DO NOT use white out. INITIAL ALL CHANGES.

Copies of all required attachments must be legible.

### (PLEASE INDICATE SPECIALTY AREA(S) IN WHICH YOU ARE REQUESTING PRIVILEGES)

- |   |   |
|---|---|
| <input type="checkbox"/> <b>Addiction Medicine</b>        | <input type="checkbox"/> <b>Physical Medicine and Rehab</b> |
| <input type="checkbox"/> <b>Allergy and Immunology</b>    | <input type="checkbox"/> <b>Podiatry</b>                    |
| <input type="checkbox"/> <b>Anesthesiology</b>            | <input type="checkbox"/> <b>Preventive Medicine</b>         |
| <input type="checkbox"/> Pain Management                  | <input type="checkbox"/> <b>Psychiatry and Neurology</b>    |
| <input type="checkbox"/> <b>Dentistry</b>                 | <input type="checkbox"/> Child Psychiatry                   |
| <input type="checkbox"/> Pediatric Dentistry              | <input type="checkbox"/> Neurology and / or Child Neurology |
| <input type="checkbox"/> <b>Dermatology</b>               | <input type="checkbox"/> Psychiatry                         |
| <input type="checkbox"/> <b>Emergency Medicine</b>        | <input type="checkbox"/> <b>Psychology</b>                  |
| <input type="checkbox"/> Toxicology                       | <input type="checkbox"/> <b>Radiology</b>                   |
| <input type="checkbox"/> <b>Family Practice</b>           | <input type="checkbox"/> Interventional Radiology           |
| <input type="checkbox"/> <b>Internal Medicine</b>         | <input type="checkbox"/> <b>Radiation Oncology</b>          |
| <input type="checkbox"/> Cardiovascular Disease           | <input type="checkbox"/> <b>Surgery</b>                     |
| <input type="checkbox"/> Endocrinology and Metabolism     | <input type="checkbox"/> Cardiothoracic Surgery             |
| <input type="checkbox"/> Gastroenterology                 | <input type="checkbox"/> Colon & Rectal Surgery             |
| <input type="checkbox"/> Hematology                       | <input type="checkbox"/> General Surgery                    |
| <input type="checkbox"/> Infectious Disease               | <input type="checkbox"/> Neurological Surgery               |
| <input type="checkbox"/> Medical Oncology                 | <input type="checkbox"/> Ophthalmology                      |
| <input type="checkbox"/> Nephrology                       | <input type="checkbox"/> Oral & Maxillofacial Surgery       |
| <input type="checkbox"/> Pulmonary Disease                | <input type="checkbox"/> Orthopedic Surgery                 |
| <input type="checkbox"/> Rheumatology                     | <input type="checkbox"/> Otolaryngology                     |
| <input type="checkbox"/> <b>Nuclear Medicine</b>          | <input type="checkbox"/> Pediatric Surgery                  |
| <input type="checkbox"/> <b>Obstetrics and Gynecology</b> | <input type="checkbox"/> Plastic Surgery                    |
| <input type="checkbox"/> Gynecology Only                  | <input type="checkbox"/> Surgical Assist                    |
| <input type="checkbox"/> Gynecology Oncology              | <input type="checkbox"/> Urology                            |
| <input type="checkbox"/> Maternal/Fetal Medicine          | <input type="checkbox"/> Vascular Surgery                   |
| <input type="checkbox"/> <b>Pathology</b>                 | <input type="checkbox"/> Other _____                        |
| <input type="checkbox"/> <b>Pediatrics</b>                |   |
| <input type="checkbox"/> Neonatal-Perinatal               |   |
| <input type="checkbox"/> Sub Specialty _____              |   |

# I. PERSONAL DATA

Confidential and only used in the event of an emergency.

- a) Name: \_\_\_\_\_  
(Last) (First) (Middle) (Title)
- b) List other names you have used: \_\_\_\_\_ Sex:  F  M
- c) Home: \_\_\_\_\_  
(Street Address) (City) (State) (Zip)
- d) Home Phone #: \_\_\_\_\_ e) Name of Spouse: \_\_\_\_\_
- f) Date of Birth: \_\_\_\_\_ g) Place of Birth: \_\_\_\_\_ h) Citizenship: \_\_\_\_\_
- i) Foreign Language(s): \_\_\_\_\_  Speak  Write j) UPIN #: \_\_\_\_\_  
(Assigned by Medicare)
- k) NPI #: \_\_\_\_\_ l) SSN: \_\_\_\_\_ m) Tax ID#: \_\_\_\_\_
- n) AHCCCS ID#: \_\_\_\_\_

# II. CURRENT PRACTICE INFORMATION

## a) Primary Office

Corporate/Group Name: \_\_\_\_\_ Office Manager: \_\_\_\_\_  
\_\_\_\_\_  
(Street Address)  
\_\_\_\_\_  
(City) (State) (Zip Code)

Phone: \_\_\_\_\_ Fax #: \_\_\_\_\_ Email: \_\_\_\_\_

Answering Service: \_\_\_\_\_ Pager: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

## b) Other Locations

\_\_\_\_\_  
(Street Address) (City) (State) (Zip)

\_\_\_\_\_  
(Street Address) (City) (State) (Zip)

\_\_\_\_\_  
(Street Address) (City) (State) (Zip)

If additional space is needed - please attach a separate sheet

c) Address to which all correspondence should be sent (IF DIFFERENT FROM Primary Office Address):

\_\_\_\_\_  
(Street Address / P.O. Box Number)  
\_\_\_\_\_  
(City) (State) (Zip Code)

Phone: \_\_\_\_\_ Fax #: \_\_\_\_\_ Email: \_\_\_\_\_

d) Associates (Name of Physicians): \_\_\_\_\_

e) Covering Physicians: \_\_\_\_\_

f) Do you sponsor / employ any Allied Health Practitioners? \_\_\_\_\_ If yes, list names, category (i.e. NP, PA):  
(Yes/No)

### III. LICENSE(S)

Attach legible copy of current license(s).

a) State: \_\_\_\_\_ License #: \_\_\_\_\_ Date Issued: \_\_\_\_\_ Date Expired: \_\_\_\_\_

### IV. EDUCATION

List all medical, osteopathic, dental or podiatric schools attended. Attach copy of Degree(s).  
See Page 5 for Post Graduate education.

a) College or University: \_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City)

\_\_\_\_\_  
(State)

\_\_\_\_\_  
(Zip)

From: \_\_\_\_\_ To: \_\_\_\_\_ Degree Earned: \_\_\_\_\_  
Month Year Month Year

Continue with additional education?  Yes  No

b) College or University: \_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City)

\_\_\_\_\_  
(State)

\_\_\_\_\_  
(Zip)

From: \_\_\_\_\_ To: \_\_\_\_\_ Degree Earned: \_\_\_\_\_  
Month Year Month Year

Continue with additional education?  Yes  No

c) College or University: \_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City)

\_\_\_\_\_  
(State)

\_\_\_\_\_  
(Zip)

From: \_\_\_\_\_ To: \_\_\_\_\_ Degree Earned: \_\_\_\_\_  
Month Year Month Year

Continue with additional education?  Yes  No

d) College or University: \_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City)

\_\_\_\_\_  
(State)

\_\_\_\_\_  
(Zip)

From: \_\_\_\_\_ To: \_\_\_\_\_ Degree Earned: \_\_\_\_\_  
Month Year Month Year

Continue with additional education?  Yes  No

### V. EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES

Please attach copy of ECFMG Certificate (if applicable)

Does Not Apply

ECFMG Certification #: \_\_\_\_\_ Date Issued: \_\_\_\_\_

## VI. POSTGRADUATE TRAINING

List all facilities where you received training. Applicant must disclose every training program initiated, whether completed or not, and all completed programs. ATTACH COPIES OF CERTIFICATES.

a) Check one:  Internship  Residency  Fellowship Specialty: \_\_\_\_\_

Facility: \_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Street Address) (City) (State) (Zip)

From: \_\_\_\_\_ To: \_\_\_\_\_ Program Director: \_\_\_\_\_  
Month Year Month Year

Completed: \_\_\_\_\_ If no, please explain: \_\_\_\_\_  
Yes/No

Continue with additional training?  Yes  No

b) Check one:  Internship  Residency  Fellowship Specialty: \_\_\_\_\_

Facility: \_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Street Address) (City) (State) (Zip)

From: \_\_\_\_\_ To: \_\_\_\_\_ Program Director: \_\_\_\_\_  
Month Year Month Year

Completed: \_\_\_\_\_ If no, please explain: \_\_\_\_\_  
Yes/No

Continue with additional training?  Yes  No

c) Check one:  Internship  Residency  Fellowship Specialty: \_\_\_\_\_

Facility: \_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Street Address) (City) (State) (Zip)

From: \_\_\_\_\_ To: \_\_\_\_\_ Program Director: \_\_\_\_\_  
Month Year Month Year

Completed: \_\_\_\_\_ If no, please explain: \_\_\_\_\_  
Yes/No

Continue with additional training?  Yes  No

d) Check one:  Internship  Residency  Fellowship Specialty: \_\_\_\_\_

Facility: \_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Street Address) (City) (State) (Zip)

From: \_\_\_\_\_ To: \_\_\_\_\_ Program Director: \_\_\_\_\_  
Month Year Month Year

Completed: \_\_\_\_\_ If no, please explain: \_\_\_\_\_  
Yes/No

Continue with additional training?  Yes  No

## VII. MILITARY/PUBLIC HEALTH SERVICE

Please attach copy of DD214 / Statement of service U.S. Public Health

Does Not Apply

In the previous 5 years, have you served or are you currently serving  Yes  No

U.S. Military  Reserves  Public Health Service

If yes, which Branch: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Type of discharge: \_\_\_\_\_  
Month Year Month Year

## VIII. PRACTICE HISTORY

Please list all positions held during the previous 5 years, in chronological order including any military experience. Leave no time period unaccounted. Information should include private practice (solo, group) and any paid employment. If additional space is needed please complete addendum page. THIS PAGE MUST BE COMPLETED IN ITS ENTIRETY. SEE CV IS **NOT** ACCEPTABLE

a) Practice/Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street Address) (City) (State) (Zip)

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Position Held: \_\_\_\_\_  
Month Year Month Year

Name and title of person who can verify this information: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

Continue with additional practice history?  Yes  No

b) Practice/Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street Address) (City) (State) (Zip)

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Position Held: \_\_\_\_\_  
Month Year Month Year

Name and title of person who can verify this information: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

Continue with additional practice history?  Yes  No

c) Practice/Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street Address) (City) (State) (Zip)

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Position Held: \_\_\_\_\_  
Month Year Month Year

Name and title of person who can verify this information: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

Continue with additional practice history?  Yes  No

## IX. TIME GAPS

You must account for time gaps less than 90 days (3 months) that occurred during the previous 5 years. All other time gaps must be included on CV.

I have no time gaps

a) From: \_\_\_\_\_ To: \_\_\_\_\_ Explain:  
Month Year Month Year

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Name and address of person to contact for verification of time gap greater than 3 months.

\_\_\_\_\_  
(Name) (Phone) (Fax)  
\_\_\_\_\_  
(Street Address) (City) (State) (Zip)

Continue with additional time gap information?  Yes  No

b) From: \_\_\_\_\_ To: \_\_\_\_\_ Explain:  
Month Year Month Year

---

---

Name and address of person to contact for verification of time gap greater than 3 months.

\_\_\_\_\_  
(Name) (Phone) (Fax)  
\_\_\_\_\_  
(Street Address) (City) (State) (Zip)

Continue with additional time gap information?  Yes  No

c) From: \_\_\_\_\_ To: \_\_\_\_\_ Explain:  
Month Year Month Year

---

---

Name and address of person to contact for verification of time gap greater than 3 months.

\_\_\_\_\_  
(Name) (Phone) (Fax)  
\_\_\_\_\_  
(Street Address) (City) (State) (Zip)

Continue with additional time gap information?  Yes  No

d) From: \_\_\_\_\_ To: \_\_\_\_\_ Explain:  
Month Year Month Year

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Name and address of person to contact for verification of time gap greater than 3 months.

\_\_\_\_\_  
(Name) (Phone) (Fax)  
\_\_\_\_\_  
(Street Address) (City) (State) (Zip)

Continue with additional time gap information?  Yes  No

# X. BOARD CERTIFICATION

List any and all Specialty Boards. Attach copy of certificate(s) or Documentation of Board Status.

a) Are you Board Certified?  Yes  No

If yes, complete questions 1 through 3

1) Name of Board: \_\_\_\_\_  
Board Name

2) Date Certified: \_\_\_\_\_ Date Recertified, if applicable: \_\_\_\_\_  
Month Year Month Year

3) Identify each date you sat or will sit for Board Exam: \_\_\_\_\_

b) Are you certified in a sub-specialty?  Yes  No If yes, complete questions 1 through 3

1) Sub-Specialty Board Name: \_\_\_\_\_  
Board Name

2) Date Certified: \_\_\_\_\_ Date Recertified, if applicable: \_\_\_\_\_  
Month Year Month Year

3) Identify each date you sat or will sit for Board Exam: \_\_\_\_\_

c) Are you certified in an additional sub-specialty?  Yes  No If yes, complete questions 1 through 3

1) Sub-Specialty Board Name: \_\_\_\_\_  
Board Name

2) Date Certified: \_\_\_\_\_ Date Recertified, if applicable: \_\_\_\_\_  
Month Year Month Year

3) Identify each date you sat or will sit for Board Exam: \_\_\_\_\_

d) If you are not Board certified, indicate current status: \_\_\_\_\_

Name of Board: \_\_\_\_\_  
Board Name

Identify dates you sat for exam:

Or will sit:

Date: \_\_\_\_\_  Passed Exam  Failed Exam

Date: \_\_\_\_\_

Date: \_\_\_\_\_  Passed Exam  Failed Exam

Date: \_\_\_\_\_

Date: \_\_\_\_\_  Passed Exam  Failed Exam

Date: \_\_\_\_\_

e)  Not Pursuing

# XI. DRUG ENFORCEMENT ADMINISTRATION REGISTRATION (DEA)

Please attach legible copy of current registration.

DEA Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

DEA Pending

I do not have a DEA

## XII. PROFESSIONAL LIABILITY INSURANCE

Please list current professional liability insurance information. You must provide information on all professional policies under which you may be covered. List ALL policies under which you've been insured for the previous fifteen (15) years. Please attach a copy of current certificate of insurance

### CURRENT CARRIERS

a) Name of Policyholder: \_\_\_\_\_ Policy #: \_\_\_\_\_

Name of Insurance Carrier: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
(Street Address) (City) (State) (Zip)

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Dates of Coverage: From: \_\_\_\_\_ To: \_\_\_\_\_ Retro Date: \_\_\_\_\_  
Month Year Month Year Month Year

Amount of coverage currently in effect: \$ \_\_\_\_\_ per occurrence/per aggregate.

Continue with additional insurance information?  Yes  No

b) Name of Policyholder: \_\_\_\_\_ Policy #: \_\_\_\_\_

Name of Insurance Carrier: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
(Street Address) (City) (State) (Zip)

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Dates of Coverage: From: \_\_\_\_\_ To: \_\_\_\_\_ Retro Date: \_\_\_\_\_  
Month Year Month Year Month Year

Amount of coverage currently in effect: \$ \_\_\_\_\_ per occurrence/per aggregate.

Continue with additional insurance information?  Yes  No

### XIII. OTHER PERTINENT INFORMATION

- a) Are you currently under investigation or have you been subject to disciplinary or corrective action such as admonition, reprimand, probation, non-provisional supervision, suspension, termination, revocation or reduction of privileges by any healthcare facility or professional organization?  Yes  No IF YES, EXPLAIN:
- 
- b) Have you ever voluntarily withdrawn / terminated your healthcare facility application / membership?  Yes  No  
Have you ever voluntarily experienced a limitation, reduction, or loss of clinical privileges at any healthcare facility?  Yes  No  
IF YES, EXPLAIN:
- 
- c) Have you ever involuntarily withdrawn / terminated your healthcare facility application / membership?  Yes  No  
Have you ever involuntarily experienced a limitation, reduction, or loss of clinical privileges at any healthcare facility?  Yes  No  
IF YES, EXPLAIN:
- 
- d) Have you ever been or are you currently the subject of an investigation, suspension or sanction from participating in any private, federal or state health insurance program (e.g., Medicare, Blue Cross)?  Yes  No IF YES, EXPLAIN:
- 
- e) Have you ever been convicted of a felony?  Yes  No  
Have you ever been convicted of a misdemeanor?  Yes  No IF YES TO EITHER QUESTION, EXPLAIN:
- 

### XIV. LICENSURE

- a) Are you currently under investigation or has any license or registration entitling you to practice your profession in any jurisdiction been censured, challenged, investigated, denied, suspended, limited, placed under stipulation or probation, revoked or been voluntarily/involuntarily relinquished?  Yes  No IF YES, EXPLAIN:
- 
- b) Have you ever been issued an advisory letter or a letter of concern/reprimand?  Yes  No IF YES, EXPLAIN:
- 

### XV. DEA

- a) Has your narcotics registration ever been limited, suspended, revoked, or voluntarily/involuntarily relinquished or is it currently being challenged/investigated?  Yes  No  N/A IF YES, EXPLAIN:
- 

### XVI. PROFESSIONAL LIABILITY INSURANCE

- a) Have you ever been denied liability insurance, in whole or in part, or has your policy ever been canceled, involuntarily restricted, denied renewal, or rated up because of the nature or volume of claims against you?  Yes  No IF YES, EXPLAIN:
- 
- b) Does your malpractice coverage exclude you from providing any specific procedure(s) or practicing portions of your specialty for which you are requesting privileges?  Yes  No IF YES, EXPLAIN:
- 
- c) Have you ever practiced without professional liability insurance?  Yes  No IF YES, EXPLAIN:
- 
- d) In the previous 5 years, have there been or are there currently pending malpractice claims, suits, settlements, judgments, arbitration proceedings, or complaints filed involving your professional practice?  Yes  No  
**IF YES TO THIS QUESTION YOU MUST COMPLETE THE ATTACHED CONFIDENTIAL INFORMATION REPORT FOR EACH INCIDENT.**



## XVII. HEALTH STATUS

a) Do you have a chronic or recurring illness, mental or physical disability that might limit or affect your ability to perform privileges requested? Yes No IF YES, EXPLAIN:

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b) Are you currently or have you in the past been dependent on or treated for alcohol or drugs? Yes No  
IF YES, EXPLAIN:

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c) Are you currently taking medication or undergoing treatment or therapy that is likely to affect your ability to perform privileges requested? Yes No IF YES, EXPLAIN:

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# RELEASE AND STATEMENT OF APPLICANT

GACCP and all Healthcare Entities receiving this information will treat all information submitted in this application as confidential and protected under Arizona state statutes.

## Please read carefully before signing

I understand and acknowledge that, as an applicant to those healthcare entities indicated in this application, it is my responsibility to provide sufficient information upon which a proper evaluation of my qualifications including my current licensure, relevant training and/or experience, current competence, health status, character and ethics can be based. I hereby pledge to maintain an ethical practice, to provide for continuous care for my patients, and to refrain from delegating the responsibility for the care of my patients to any practitioner not qualified to undertake that responsibility. I further understand and acknowledge that the Maricopa County Medical Society's Greater Arizona Central Credentialing Program (GACCP), acting as agent for the healthcare entities, will verify the information in this application. I further understand that healthcare entities may also independently investigate my qualifications. By submitting this application, I agree to such verification and to the information exchange activities of GACCP and the healthcare entities. I further acknowledge that I am responsible for knowing the contents of the bylaws, rules and regulations, and code of conduct of the healthcare entities and their medical staffs and agree to be bound by them. I understand and acknowledge that completing this application does not entitle me to membership or privileges at any of the healthcare entities and that GACCP shall have no responsibility or liability with respect to healthcare entities' membership decisions. I further understand and agree that GACCP is solely responsible for the information which it provides to healthcare entities and that healthcare entities shall have no responsibility or liability for the completeness or accuracy of this information insofar as it was provided by GACCP or verified by GACCP.

Verification of Application. I hereby authorize all individuals, institutions, and entities, (past, present, and future) including all professional liability insurers with whom I have had or currently have professional liability insurance (including past and present claims history), who have knowledge concerning my qualifications and other information requested in this application to consult with, and release relevant information and/or records to the healthcare entities, their medical staffs and agents, specifically including but not limited to GACCP.

I further authorize the use of the pictures provided by me for internal/ external purposes.

Authorization of Release. I understand and agree that the authorizations given by me herein shall be irrevocable for a period of twenty-four (24) months. A photocopy of this waiver shall be as effective as the original when so presented.

All information provided by me in this application is correct and complete to the best of my knowledge and belief. I understand and agree that any material misstatement in or omission from the application may constitute grounds for denial of appointment or for summary dismissal from the healthcare entities. I further release from liability and from any restrictions as to confidentiality and/or privacy, all representatives of GACCP, the hospitals, healthcare entities, their boards and medical staffs, and further release all medical schools, licensing boards, specialty societies and all other entities and individuals providing information from liability for their acts performed in connection with the gathering and exchange of information as consented to above.

I agree to update this application while it is being processed, should there be any change in the information provided that could affect this application or its outcome.

I hereby agree that the exclusive remedy for any decision or recommendation made pertaining to this application for appointment or in any other peer review proceeding shall be to seek review of the correctness of the decision or recommendation, that no claim for alleged monetary damages will be brought on account thereof, and that no action at law or inequity will be brought until after all appeal rights available under the healthcare entities' medical staff bylaws/contracts have been exercised and completed.

I agree to notify GACCP and the healthcare entities within ten (10) days of notice of any suit or claims alleging malpractice or malfeasance against me. I further agree to notify GACCP and the healthcare entities thirty (30) days prior to any change in malpractice insurance coverage.

Name: \_\_\_\_\_  
(Please Print)

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

# MEDICARE ATTESTATION STATEMENT

## NOTICE TO PRACTITIONERS

"Medicare, and/or other federally funded program payments to healthcare entities are based on each patient's principal and secondary diagnosis and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal funds, may be subject to fine, imprisonment, or civil penalty under applicable federal laws."

I acknowledge that I have read the above statement.

Name: \_\_\_\_\_  
(Please Print)

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

