DEPARTMENT OF THE ARMY
US ARMY MEDICAL DEPARTMENT ACTIVITY
BOX 105109
FORT IRWIN, CA 92310-5109

REPLY TO
ATTENTION OF

STATEMENT OF APPLICANT

All information submitted by me in this application is true to the best of my knowledge and belief. I fully understand that any significant misstatements or omissions from this application constitute cause for denial of appointment or cause for summary dismissal from the medical staff.

In making this application for appointment to the medical staff of Weed Army Community Hospital, I acknowledge my obligation to provide continuous care and supervision of my patients, to accept committee/team assignments, to accept consultation assignments and to participate in staffing the emergency service area and other special care units.

By applying for appointment to the medical staff, I hereby signify my willingness to appear for interviews in regard to my application. I hereby authorize the hospital, its medical staff and their representatives to consult with administrators and members of the medical staffs of other hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by the hospital, its medical staff and its representatives of all documents, including medical records at other hospitals that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested, as well as my moral and ethical qualifications for staff membership.

I hereby release from liability all representatives of the hospital and its medical staff for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to the hospital, or is medical staff, in good faith and without malice concerning my professional competence, character and other qualifications for staff appointment and clinical privileges, and I hereby consent to the release of such information.

I hereby further authorize the hospital to communicate to other hospitals and to other persons or organizations with a legitimate interest therein any information concerning my professional competence, character and ethics that the hospital may have or acquire, and where such communication is made in good faith and without malice, and I consent to thereto agree to hold the hospital and its authorized representatives free of liability therefore.

I understand and agree that I, as an applicant for medical staff membership or privileges, 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 such qualifications.

I particularly agree to subject my clinical performance to, and faithfully participate in, the hospital's performance improvement and quality assurance programs as the same shall from time to time be in effect, and I agree to hold members of the medical staff and other authorized representatives of the organization engaged in these performance improvement/quality assurance activities free of all liability for their actions performed in good faith in connection therewith.

I fully understand that all privileging actions, to include adverse privileging actions, will be conducted in accordance with AR 40-68, Quality Assurance Administration. Adverse privileging actions may be reported to the Nation Practitioner Data Bank pursuant to 42 USC 11111-11152.

I authorize and release from all liability the Commander, the Credentials Committee and/or their representative of MEDDAC to consult with, request from and/or release information to personnel at institutions and organizations pertaining to my credentials/qualifications.

_____ _____

Date Signature