PHYSICIAN CONDITIONS OF APPLICATION
WAIVER OF LIABILITY AND CONSENT FOR RELEASE OF INFORMATION

By submitting an application for Participating Provider status with Quad City Community Healthcare (QCCH), I AGREE:

- that this is an application for Participating Provider status with QCCH;
- authorize QCCH to consult with members of the hospital medical staff, professional liability carriers, and other persons or entities that have knowledge concerning my professional medical qualifications;
- agree that QCCH may delegate the credentialing process to a nationally recognized accredited delegation service or participating Hospital/Surgery Center, with the understanding that QCCH does not have any power to affect decisions made by delegated entity or Hospital/Surgery Center privileges as Hospital/Surgery Center privileges are reached solely by the governing bodies of each such institution.
- understand that the final decision for the approval of Participating Provider status with the Health Plan remains with Quad City Community Healthcare and agree to appear for interviews in regard to my application;
- authorize the delegated entity or Health Plan to consult with my prior associates and others, including without limitation any insurance carrier or governmental agency or disciplinary or licensing body who may have information bearing on my professional competence, quality assurance data relating to me, character, ability to practice, ethical qualifications, and ability to work cooperatively with others;
- consent to inspection by the delegated or Health Plan of all documents that may be material to an evaluation of my qualifications and competence and/or release by any person or entity to Quad City Community Healthcare;
- release from liability to the fullest extent permitted by law the delegated entity (Hospital(s)/Surgery Center) or Health Plan for their acts performed and statements made in good faith regarding the collection, dissemination and evaluation of my credentials, and all information pertaining to my application;
- release from liability to the fullest extent permitted by law any and all individuals and organizations who in good faith provide information to the delegated entity or Health Plan concerning my professional competence, ethics, character and other qualifications for Staff appointments and clinical privileges;
- agree that I have the burden of producing adequate information for proper evaluation of my professional, ethical and other qualifications for appointment and clinical privileges and for resolving any doubts about such qualifications;
- acknowledge that any significant misstatements in or omissions from this application constitute cause for denial of Participating Provider status and will be cause for summary dismissal from the Health Plan;
- now meet and will continue to maintain at least the minimum professional liability insurance coverage required by Quad City Community Healthcare to which I am applying and pledge further that I will immediately notify the Health Plan in writing of any change in my professional insurance coverage.
- agree that this application shall not be considered complete until query is made to and received from the National Practitioner Data Bank by the delegated entity or Health Plan.
- further agree that a photocopy of this document will serve as a current duplicate original for a period of three years from the date below.

All information submitted by me in this application is true to the best of my knowledge and belief. I further certify that I am personally responsible for the accuracy of the responses submitted as part of this application.

PRINT NAME: ______________________________

SIGNATURE: ______________________________

DATE: ______________________________