CONDITIONS OF COMPLETING THE CREDENTIALS FORM

BY COMPLETING THIS CREDENTIALS FORM, I HEREBY:

- Signify my willingness to appear for interviews in regard to my application.
- Authorize Gateway Health Alliance and any other carrier, and its staff to consult with others who may have information bearing on my professional competence, character, ethical qualifications and ability to work cooperatively with others and perform my professional duties.
- Consent to the inspection by all representatives of Gateway Health Alliance and its staff of all documents that may be material to an evaluation of my qualifications and competence.
- Release from liability Gateway Health Alliance and any other carrier, all representatives and employees of Gateway Health Alliance and any other carrier, for their acts performed and statements concerning my credentials and qualifications.
- Release from liability any and all individuals and organizations who provide information to Gateway Health Alliance any other carrier, and its staff concerning my professional competence, ethics, character and other qualifications for staff appointment and clinical privileges needed per hospitals.
- Pledge to maintain an ethical practice, to provide for the continuous care of my patients, and to refrain from delegating the responsibility or care of my patients to any person not qualified to undertake that responsibility.
- Acknowledge that I, as an applicant for participation in Gateway Health Alliance have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications for such participation and for resolving any doubts about such qualifications.
- Acknowledge that any significant misstatements in, or omissions from, this credentials form constitute cause for denial of participation or cause for summary dismissal from Gateway Health Alliance.
- Certify all information given by me to the foregoing questions and statements on this credentials form is true and correct without omissions of any kind.
- Assert that I am clinically competent to perform all of the procedures/surgeries, which I currently perform.
- Give my permission for the release of my utilization as compiled in the Data Medical database, or other similar comparative utilization databases, at hospitals where I hold staff appointments and clinical privileges.
- Acknowledge that Gateway Health Alliance and any other carrier, as a health care entity, is involved in querying the National Practitioner Data Bank, American Medical Association, Federation of State Medical Boards, and Board of Medicine as recommended.
- Understand and agree that nothing on this credentials form is intended to imply or create an employment relationship or contract for employment, nor does it guarantee approval of a contract for service.
- Certify that I have completed the required Category I CME hours for my specialty, which are accredited by the Accreditation Council for CMEs, which meet the criteria for the Physician's Recognition Award for the AMA.
- By signing this, I attest that the information provided on my most recent Gateway application remains complete and correct.

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Signature *(No Signature Stamps Accepted)* Date

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Print Name