

**APPLICANT'S CONSENT AND RELEASE**  
**Applicant's Responsibility**

1. I apply for panel appointment and practice privileges as requested as above. I am willing to make my self-available for interviews in regard to this application and intend to be legally bound by the terms of this consent and release.
2. As an applicant for panel appointment, I understand that it is my responsibility to produce adequate information so that Health Partners can perform a proper evaluation of my qualifications. I agree to provide Health Partners with updated information regarding all questions on the application form, as new Information becomes available. I also agree to provide Health Partners with additional information that it or one of its authorized representatives may request. Failure to produce any requested information will prevent my application from being processed.
3. I understand that upon request, I will be informed of the status of my credentialing or recredentialing application. I understand that I have the right to review information obtained from any outside primary source to evaluate your application (e.g. malpractice insurance carriers, state licensing boards and National Practitioner's Databank- NPDB). This standard does not require Health Partners to allow a physician to review references or recommendations or other information that is peer review protected. If we obtain information that varies from the information submitted, you will have the ability to correct any erroneous information that may differ from your application. Upon completion, you will be informed in writing of the committee's credentialing decision.

**Terms and Conditions of Panel Appointment and Practice Privileges:**

1. By applying for panel appointment and practice privileges at Health Partners, I accept the terms and conditions set forth below and intend to be legally bound thereby:
  - a. Clinical privileges at Health Partners are not a right of every licensed professional who makes application for same;
  - b. My request will be evaluated in accordance with prescribed procedures defined in Health Partner's policies, rules and regulations, and directives;
  - c. Payor Contract acceptance is contingent upon the physician meeting credentialing standards. If the credentialing process is incomplete at the time of contract acceptance and the predetermined standards are not met, the physician will not be accepted in its panel;
  - d. All recommendations relative to my application are subject to the ultimate action of the Board of Directors;
  - e. I have the responsibility to keep this application current by informing Health Partners of any change, including but not limited to any change in my professional liability insurance coverage, the filing of a lawsuit against me, and any change in my medical staff status at any hospital or health care facility; and
  - f. Reappointment and continued practice privileges remain contingent upon my continued demonstration of professional competence and cooperation, my general support of Health Partners, and acceptable performance of all related responsibilities, as well as the other factors relevant by Health Partners.

**Undertakings:**

1. I specifically agree to abide by the policies, rules and regulations, and directives that are in force during the time I am applying to Health Partners.
2. If granted panel appointment and practice privileges, I specifically agree to:
  - a. Abide by generally recognized ethical principles applicable to my profession;
  - b. Provide continuous care and supervision as needed to all patients for which I have responsibility; and
  - c. Accept committee assignments and such other duties and responsibilities as shall be assigned to me.

**RELEASE AND IMMUNITY**

By applying for panel appointment and practice privileges, I accept the following conditions, regardless of whether I am granted appointment or privileges, and intend to be legally bound thereby. These conditions shall remain in effect for the duration of any term I may be granted.

I hereby give Mount Carmel Health Partners, Inc. (“Health Partners”), its affiliates and the employees, agents and representatives, and credentialing agents, thereof, permission to obtain information about my professional education, training, licensing, competence, ethics, character, hospital credentials, utilization review data, malpractice claims history, adverse actions by a hospital or other agency (**such as Medicare or Medicaid**) and any other information requested by Health Partners prior to any decision regarding participation privileges (**my “Credentialing Information”**).

I consent to the release of my Credential Information, whether in the form of transcripts, tapes, letters, photocopies and/or duplications of any of the foregoing, or verbal statements and/or related information (**where verbal statements from specified sources are recognized as primary verification by NCQA or another recognized accrediting organization**), by the following parties or their representatives: hospital administrators, chiefs of clinical departments of hospitals in which I have served on staff, state licensing boards or regulatory bodies (by whatever name known in their respective jurisdictions), physicians, clinics, or other individuals or organizations who or which possess **credentialing-related** information about me.

I specifically authorize Health Partners, its affiliates and the employees, agents and representatives thereof to consult with any third party concerning my Credentialing Information, and to inspect or obtain any and all communication, reports, records, statements, documents, recommendations or disclosures of such third parties related to **Credentialing Information**.

I hereby specifically consent to, authorize and direct the release of my Credentialing Information to third party payers (either directly or as Health Partners acting as my agent) if a third party requests my Credentialing Information for the purpose of permitting me to participate in a third party payer agreement. I understand that such payer’s participation requirements may differ from Health Partners’ participation requirements and such payer may retain the right to approve, terminate or suspend a provider’s participation in such payer’s plan.

I hereby release from liability and agree to hold harmless any person or entity who or which provides my Credentialing Information as authorized herein.

I hereby release from liability and agree to hold harmless Health Partners, its affiliates and the employees, agents and representatives thereof for acts performed and statements made, in good faith and without malice, in connection with obtaining, reviewing, and evaluating my credentials and qualifications, including but not limited to my competence, professional ethics, character and health status. I further acknowledge that my cooperation by consent to the production of such information about me does not guarantee that Health Partners will contract with me as a provider of services. I acknowledge that the credentialing process is needed for review and evaluation by Health Partners and its representatives to determine whether I am qualified to serve as a provider of services of Health Partners or for a particular payer and whether the services I provide fit the business needs of Health Partners.

1. The term “Health Partners and its authorized representatives” means Health Partners and any and all of its individuals who have any responsibility for obtaining or evaluating my credentials or acting upon my application or conduct Health Partners.
2. The term “third parties” means any and all individuals from whom information has been requested by Health Partners or its authorized representatives or who have requested such information from Health Partners and its authorized representatives.

**Affirmation**

I represent that information provided in or attached to this application is accurate. I understand that a condition of this application is that any misrepresentations, misstatements, or omissions from this application, whether intentional or not, is cause for automatic and immediate rejection of this application and may result in the denial of panel appointment or practice privileges. Upon subsequent discovery of such misrepresentation, misstatement or omission, Health Partners may immediately terminate my panel appointment and practice privileges.

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Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date