

**WAIVER OF LIABILITY &  
CONSENT FOR RELEASE OF INFORMATION**  
Jamestown Hospital  
Jamestown, North Dakota

In return for my application being considered, I agree to be legally bound to the following terms and conditions:

1. The information given in or attached to this application is accurate and complete to the best of my knowledge, information, and belief. I understand that it is my responsibility to produce adequate information so that a thorough and proper evaluation of my application can be performed. I will provide entities to which I am applying updated information regarding all questions on this application form as such information becomes available and will provide such additional information as may be requested by any of these entities. Failure to produce any requested information will prevent my application from being processed. I am willing to make myself available for interviews in regard to this application.
2. I have received and have had an opportunity to read the job description to which I am applying for appointment and clinical privileges. I specifically agree to abide by the documents that are in force during the time I am employed.
3. To the fullest extent permitted by law, I extend immunity to, release from any and all liability, and agree not to sue those entities and entity representatives to which I am submitting my application for clinical privileges and appropriate third parties, and/or which perform delegated credentialing, professional peer review and quality assessment/performance improvement functions, in connection with any matter pertaining to the application, appointment, reappointment or professional review activity, including the following entities or individuals:
  - a. entities to which I have applied for clinical privileges, including reappointment; and
  - b. persons or organizations providing information to such entities regarding any credentialing, peer review, recommendations, reports, statements, actions communications, or disclosures involving me, which are made, taken, or received and are related to my application for clinical privileges; and
  - c. persons or entities receiving credentialing or peer review information from such entities or such entities' representatives to the extent related to my application for clinical privileges; and
  - d. any other professional review activity related to my application for clinical privileges;
4. I authorize the above referenced organization and persons to share information with each other and consult with third parties regarding my clinical competence, professional conduct, character, ethics, behavior, or other matter bearing on my qualifications or my ability to perform the functions of the position(s) for which I am applying. This includes the right to obtain all documents, recommendations, reports, statements or other information relating to such matters not protected by confidentiality or privilege under any federal or state law or regulation.
5. The term "professional review activity" means any action or communication by any of the organizations or persons referenced above related to any:

- a. determination as to whether I may have clinical privileges with respect to, or membership, appointment, contract or participating provider status with, any of said organizations;
- b. determination related to the scope or conditions of such status;
- c. change, modification, suspension or termination of such status; or
- d. review, recommendation or evaluation related to such status or otherwise related to my clinical competence or professional conduct.

**6. I hereby certify that:**

- a. My license to practice my profession in any state and my clinical privileges have never been denied, revoked, or terminated by any hospital or health care facility for reasons related to clinical competence or professional conduct.
- b. I have never been convicted of Medicare, Medicaid or other governmental or private third-party payor program fraud or abuse or required to pay civil money penalties for the same.
- c. I have never been convicted of any criminal felony or misdemeanor relating to the practice of my profession, any other health care related matters, third-party reimbursement, or controlled substance violations.
- d. I have never been excluded or precluded from participation in the Medicare program or any state Medicaid program.
- e. I am able to perform safely and competently the essential functions of the positions for which I am applying, and am not presently using any illegal drugs nor any other substance that would impair my ability to perform those essential functions.

**7. Specifically for Jamestown Hospital, I agree to adhere to the Corporate Compliance Plan of Jamestown Hospital and any laws, regulations and standards of conduct applicable to my profession, participation in any federal health program or activities at Jamestown Hospital and report any known or suspected violation of the same by myself or by any officer, manager, employee or other medical staff appointee to Administration or the Human Resource Manager.**

**8. Any intentional misrepresentation, misstatement, or omission from this application is cause for the immediate cessation of the processing of this application and no further processing shall occur. Upon subsequent discovery of such misrepresentation, misstatement, or omission, any of those entities to which I am applying may deem any relationship they have with me to be automatically relinquished, including but not limited to clinical privileges.**

**9. I acknowledge that Jamestown Hospital to which I am submitting my application and its board of directors may apply such criteria as they deem appropriate in acting on my application. I will accept the final decision of such entity/board with respect to my application.**

\_\_\_\_\_ **Date**

\_\_\_\_\_ **Signature of Applicant**

**Applicant Name:**

**You may request a copy of the Clinical Reference Form for your review.**