GENERAL INDEMNIFICATION STATEMENT

(To be completed by applicants NOT EMPLOYED by Millard Fillmore Surgery Center, LLC i.e. not receiving a Millard Fillmore Surgery Center, LLC Payroll check)

Re: ________________________________ (applicant name)

- I hereby verify that the above-named individual is in my employment and/or under my supervision as described on the attached job description/delineation.
- I hereby agree to be responsible for all of the duties performed by the above-named person in the performance of responsibilities as a Health Professional Affiliated of the Millard Fillmore Surgery Center, LLC under my supervision.
- I also agree to notify Millard Fillmore Surgery Center, LLC when he/she leaves my/our practice or if his/her capacity changes in any way.
- I further agree to indemnify the Millard Fillmore Surgery Center, LLC for any and all claims, demands and liabilities arising from the acts and duties in professional practice of the candidate while employed and supervised by me.

Signed: ________________________________

Signature - Supervising/Employing Physician

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Please Print Name

Date: ________________________________