CERTIFICATIONS, AUTHORIZATIONS AND WAIVERS OF LIABILITY

I fully understand that any misstatements in, or omissions from, this application or the supporting documentation submitted herewith, constitutes cause for denial of the application or cause for summary dismissal as a Health Professional Affiliate of Millard Fillmore Surgery Center, LLC. All information submitted by me in connection with this application is true and complete to the best of my knowledge and belief and no pertinent information has been omitted.

In making this application to the Health Professional Affiliate Staff of Millard Fillmore Surgery Center, LLC, I acknowledge that I have received and read the Health Professional Affiliate Manual. If I am granted membership, I agree to be bound by the terms thereof in all matters relating to my appointment to the Health Professional Affiliate Staff, and I further agree to abide by such Hospital and Health Professional Affiliate Staff Rules and Regulations and Policies as may be from time to time amended and enacted.

By submitting my application to the Health Professional Affiliate Staff, I hereby authorize Millard Fillmore Surgery Center, LLC and its representatives to consult with administrators and members of the Medical/Dental Staff(s) of other hospitals or institutions with which I may have been associated and with others, including past and present malpractice insurance carriers, who may have information bearing on my professional competence, character and ethical qualifications in regard to my application. I hereby further consent to the inspection by Millard Fillmore Surgery Center, LLC and its representatives of all records and documents, including medical records from hospitals that may be made material to an evaluation of my professional qualifications and competence to provide care within the scope of practice requested, as well as my moral and ethical qualifications for staff membership. I hereby release from liability Millard Fillmore Surgery Center, LLC and its representatives for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications. I hereby release from any liability any and all individuals and organizations, including the facility, their Medical/Dental Staffs and their representatives, who provide information to Millard Fillmore Surgery Center, LLC or its Staff in good faith and without malice concerning my professional competence, ethics, character and other qualifications, and I hereby consent to the release of such information.

I understand and agree that I, as an applicant for Health Professional Affiliate status, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any questions or doubts about such qualifications. **I have been advised of, and hereby acknowledge, my obligation to advise Millard Fillmore Surgery Center, LLC in writing immediately of any new, different or additional information responsive to any of the questions or items requested in or in connection with this application which, at anytime, comes to my attention or is made known to me.**

_____ _____

DATE **SIGNATURE OF APPLICANT**