

**XII. AUTHORIZATION AND CERTIFICATION**

**Statement of Application** (please read carefully before signing)

I specifically authorize Health Alliance Medical Plans and its authorized representatives to consult with any third party who may have information bearing on my professional qualifications, licensure, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter, as well as to inspect or obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of said third parties. I specifically authorize said third parties to release said information to Health Alliance Medical Plans and its authorized representatives upon request.

I also authorize Health Alliance Medical Plans and its authorized representatives to provide to hospitals, medical associations, licensing boards, governmental agencies, health plans and other organizations concerned with provider performance and quality and efficiency of patient care any information relevant to such matters that Health Alliance Medical Plans may have concerning me, and release from any liability for so doing all representatives of Health Alliance Medical Plans, providing such information is furnished in good faith and without malice.

To the fullest extent permitted by law, I extend absolute immunity to, and release and hold harmless from any and all liability, Health Alliance Medical Plans and its authorized representatives and any third party for any acts, communications, reports, records, statements, documents, recommendations or disclosures involving me, performed, made, requested, or received by Health Alliance Medical Plans and its authorized representatives to, from, or by any third party, including otherwise privileged or confidential information made or given in good faith. This indemnification and hold harmless is given with the understanding that Health Alliance will act in good faith with respect to each matter addressed and that it will use its best efforts to maintain the confidentiality of the information and records received by it from third parties.

I also certify that the information given in or attached to this application is complete, accurate, and fairly represents the current level of my training, experience, capability and competence to practice. I further understand that any further misrepresentations, misstatement in, or omission from this application whether intentional or not, shall, of itself alone, constitute cause for automatic and immediate rejection of this application. In the event this application is approved prior to the discovery of such misrepresentation, misstatement, or omission, such discovery may result in termination for cause of any agreement made as a result of this application by and between Health Alliance Medical Plans and myself.

I agree to notify Health Alliance Medical Plans immediately with respect to any of the following involving myself or any individual provider of health care services employed or retained under contract by myself: (i) any inquiry, investigation, action or proceeding with respect to licenses, Drug Enforcement Act registration or any change in certification or accreditation by any association or organization; (ii) any claim, notice of claim or legal action filed or threatened in connection with the rendering of health care services; (iii) any adverse malpractice judgments; and (iv) any inquiry, investigation, action or proceeding with respect to participation in any government program as a provider of Health Care Services, including but not limited to Medicare, Medicaid, Maternal and Child Health Services Block Grant and Block Grants to States for Social Services programs.

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Print Name

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Signature

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Date