

SWLA CENTER FOR HEALTH SERVICES

APPLICANT'S CONSENT AND RELEASE

I hereby apply for employment and clinical privileges as requested in this application and, whether or not I am employed, I acknowledge, consent to, and agree as follows:

As an applicant for employment and clinical privileges, I have the burden for producing adequate information for proper evaluation of my qualifications. I also agree to provide any additional information as may be requested by the facility.

Information given in or attached to this application is accurate and complete to the best of my knowledge. Discovery of any misrepresentations, misstatements or omissions, whether intentional or not, shall constitute cause for immediate rejection of this application. In the event that employment and privileges have been granted prior to the discovery of such misrepresentation, misstatements or omissions, such discovery may result in immediate termination of such employment and privileges.

I accept the following conditions:

- A.) I extend immunity to, and release from any and all liability, SWLA Center for Health Services, its authorized representatives and any third parties, for any acts, communications, or disclosures performed, made, requested, or received by SWLA Center for Health Services, its authorized representatives to, from or by any third party, involving this application.
- B.) I specifically authorize the facility and its authorized representatives to consult with any third party who may have information bearing on my professional qualifications, credentials, competence, character, mental or emotional stability, physical condition, ethics, behavior, or any other matter bearing on my satisfaction of the criteria for employment, as well as to inspect or obtain any and all communications, reports, records, statements, documents, recommendations and/or disclosures of said third parties relating to such questions. I also specifically authorize said third parties to release said information to SWLA Center for Health Services and its authorized representatives upon request. I agree that a photocopy or telephonic facsimile of this authorization shall be as valid as the original.

If employed and granted clinical privileges, I specifically agree to: (1) abide by all medical bylaws, policies, directives rules and regulations as are in force and as they may hereafter be amended during the time I am employed and exercise clinical privileges at SWLA Center for Health Services, (2) refrain from delegating responsibility for diagnoses or care of patients to any other practitioner who is not qualified to undertake this responsibility, (3) seek consultation whenever necessary or required, (4) abide by generally recognized ethical principles applicable to my profession, (5) provide continuous care and supervision as needed to all SWLA Center for Health Services patients for whom I have responsibility.

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Applicant's Signature

Date