INFORMATION RELEASE/ACKNOWLEDGMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance ("credentialing information") by and between this Healthcare Organization(s) and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations {IPAs}, health plans, health maintenance organizations {HMOs}, preferred provider organizations {PPOs}, other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies {with respect to certification of coverage and claims history}, licensing authorities, and businesses and individuals acting as their agents (collectively, Healthcare Organizations"), for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state and federal law and regulation, including but not limited to, California Business and Professions Code §809 *et seq,* if applicable.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

In addition to any notice required by any contract with a Healthcare Organization, I agree to notify this Healthcare Organization immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or non-renewal of my license to practice medicine in California; (ii) any suspension, revocation or non-renewal of my DEA or other controlled substances registration; or (iii) any cancellation or non-renewal of my professional liability insurance coverage.

I further agree to notify this Healthcare Organization in writing, promptly and no later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me by the Medical Board of California taken or pending, including but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization which has resulted in the filing of a Section 805 report with the Medical Board of California or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

ATTESTATION

I HEREBY AFFIRM THAT ALL THE INFORMATION SUBMITTED IN THIS APPLICATION AND ANY ADDENDA THERETO (INCLUDING MY CURRICULUM VITAE IF ATTACHED) IS TRUE, CURRENT, CORRECT, AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF AND IS FURNISHED IN GOOD FAITH. I ATTEST TO THE CORRECTNESS AND COMPLETENESS OF THE INFORMATION PROVIDED IN SECTION 10 (ATTESTATION QUESTIONS). I UNDERSTAND THAT MATERIAL OMISSIONS OR MISREPRESENTATIONS MAY RESULT IN DENIAL OF MY APPLICATION OR TERMINATION OF MY PRIVILEGES, EMPLOYMENT OR PHYSICIAN PARTICIPATION AGREEMENT. I AGREE TO PROVIDE CONTINUOUS PATIENT CARE IN COMPLIANCE WITH RESPECTIVE UCLA HEALTHCARE ORGANIZATION BYLAWS, RULES AND REGULATIONS. I ALSO AGREE TO ABIDE BY THE UCLA MEDICAL ENTERPRISE CONFIDENTIALITY STATEMENT. I HAVE RECEIVED, READ AND AGREE TO ABIDE BY THE BYLAWS FOR THE RESPECTIVE UCLA HEALTHCARE ORGANIZATIONS TO WHICH I AM APPLYING.

Practitioner Signature_____Date: _____
(Stamped Signature Is Not Acceptable)

Practitioner Name: _____