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**Declaration**

I declare that the information contained in the application are true, correct and complete. I understand that falsification, misrepresentation or omission of any fact(s) will be sufficient cause for denial of this application and/or subsequent termination of any participating privileges granted upon the basis of this application.

**Notification of Change**

I agree to inform TCN in writing of any changes in the answers or information provided on the application as a result of new information or developments subsequent to my signing of the application within fifteen (15) days of my awareness of the new information.

**Release of Information**

I understand that the information contained in this application will be used to evaluate my credentials according to the quality assessment standards of TCN. I do hereby grant TCN and its contracting health plans and/or its authorized agent(s), permission to gain access to, inspect and duplicate any and all information, records, summaries of records, statistical reports (including utilization profiles pertinent to my provision of medical services), credentialing and peer review information and reports relative to my professional qualifications from any and all acute care facilities, skilled nursing facilities, outpatient centers, and any other institutions with which I am now or have been or will be affiliated, and local county, state and federal medical trade associations, accrediting or private agencies or association, organization, medical societies or governmental entities.

I authorize TCN to release information in or related to this application to any entity which under contract or law has an obligation to provide or arrange for the provision of medical services of TCN, contracting health plans and authorized agents and representative of local, state, and federal government agencies.

**Release of Liability**

I hereby release TCN, its shareholders, directors, officers, agents, employees, contracting Health Plans, independent contractors and other individuals from any and all liability (and expenses which are directly or indirectly incurred) as a result of the described site visit inspection, duplication or release of information, or provide any and all information or opinions concerning myself to TCN or Health Plans concerning my professional practice, competence, ethics, character and other qualification for appointment and privileges and I hereby agree to the release of any and all such information.

**Rights and Privileges**

I understand and agree that acceptance of this application does not constitute approval or acceptance of participating status in TCN and grants me no rights or privileges of participation until such time as I receive written notice of acceptance by TCN Board of Directors.

**Copies**

I further agree that a facsimile transmission or copy of this document will serve as a duplicate original.

**Policies and Procedures**

I understand and agree to be bound by the credentialing policies and procedures of TCN.

**Consent to Site Visits and Interview**

I understand and agree to sites visits and an interview as required in the credentialing policies and procedures.

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_