

Agreement of Applicant, Release of Information, and Release of Liability

In furtherance of my application for membership and privileges on the medical or allied health or ancillary staff (collectively the "Medical Staff") of Banner Gateway Medical Center, I authorize the release of my past and future Medical Portfolio as described below. My "Medical Portfolio" consists of any and all information and documents including supervisory reports that is used or that may assist in the evaluation of my qualifications for Medical Staff membership and privileges. My Medical Portfolio includes without limitation information regarding:

- ❖ The quality, efficiency and effectiveness of patient care;
- ❖ My character, conduct, collegiality and compliance with professional ethics and legal requirements;
- ❖ My health status;
- ❖ My medical education, training and competence;
- ❖ My affiliations with other medical staffs, my performance at other facilities, and any limitations or restrictions imposed or pending with respect to all other such memberships and privileges;
- ❖ Licenses I have been granted and any license restrictions imposed or pending;
- ❖ Criminal background check;
- ❖ All professional liability (malpractice) claims or suits to which I am or have been a party, or that involve care I provided to a patient.

This Release is granted in favor of the Board of Directors of Banner Health and all employees and agents of Banner Health, including the employees and members of the Medical Staff of Banner Gateway Medical Center who are involved in processing, reviewing, or making recommendations regarding my application. I understand that Oncology Services at Banner Gateway Medical Center are provided in conjunction with M. D. Anderson Physicians Network. To the extent that My Portfolio may be selected by M. D. Anderson Physicians Network to be part of a random audit of the credentialing process at Banner Gateway Medical Center, or to the extent that any clinical privileges I have requested involve the provision of Oncology Services, I further authorize Banner Health to share my Medical Portfolio with the M. D. Anderson Physicians Network and the University of Texas M. D. Anderson Cancer Center and their physician and employees involved in reviewing and processing physician credentials.

Release of Information: I authorize hospitals, healthcare institutions, medical staff members, training programs, managed care organizations, insurance carriers and all persons associated with them or otherwise having knowledge of my Medical Portfolio to release all information regarding my Medical Portfolio to Banner Gateway Medical Center or its designees, including the Banner Credentialing Verification Organization. I release from liability and from any restrictions as to confidentiality or privacy any and all individuals or organizations or their representatives who provide information about me at the request of Banner Gateway Medical Center or its designees. I further agree that any act, communication or disclosure regarding my Medical Portfolio made to a Banner Health facility or entity, or at the request of any other health care facility, is privileged to the fullest extent permitted by law.

I acknowledge that I have the burden of producing adequate information for a proper evaluation of my qualifications for membership and privileges. In addition to the information provided in this application, I agree also to provide Banner or its authorized representatives with all additional information that may be requested. My failure to provide requested information will cause my application to be incomplete, and it will not be processed. If and when requested, I will appear for and cooperate in interviews and will submit to an examination of my health status or professional competence. Pictures of me may be used for identification purposes in conjunction with my application and, if membership is granted, with my role as a member of the Medical Staff.

I acknowledge receipt of the Banner Sharing of Peer Review Information policy, and in accordance with that policy I authorize the sharing of information among all Banner Health facilities or entities at which I have privileges or to which I have applied.

Release of Liability: I agree to release from legal liability and hold harmless Banner Health facilities/entities, medical staffs, and all persons engaged in peer review and/or quality assurance activities, including but not limited to the review of my application for appointment and reappointment. I further acknowledge and agree that the right to seek injunctive relief pursuant to A.R.S. §35-445 et seq. is my sole remedy for any corrective action taken or recommended by the Medical Staff for failure to comply with medical staff bylaws or fair hearing plans or for any other peer review or quality assurance actions. I agree that no claim for monetary damages may be brought until all appeal rights available under medical staff bylaws have been exhausted. I further agree to comply with the immunity provisions in the medical staff bylaws. I understand this Release of Liability applies regardless of whether my application is granted.

Conditions of Application: Completing this application does not entitle me to membership or privileges. Receipt of this Application by Banner Gateway Medical Center does not constitute my acceptance by Banner Gateway Medical Center.

I have read and understand and I agree to abide by Banner Health Bylaws and policies, including but not limited to those regarding HIPAA, Electronic Transmission of Patient Information and excluded practitioners and, if I am applying for hospital medical staff

membership, the Banner Health Code of Conduct. I further agree to comply with the Banner Gateway Medical Staff Bylaws, Rules and Regulations, Department Rules and Regulations and the Professional Conduct Policy.

I have personally completed this Application or have reviewed its contents and attest to its completeness and accuracy. All information in this application is truthful, correct and complete to the best of my knowledge and belief. Should there be any change in the information while the application is being processed, I agree to update it. I understand that the failure to provide accurate and complete information on this Application or in response to requests for further information is grounds for denial or termination of membership, including summary dismissal.

I agree to immediately notify the Medical Staff Services Office of any of the following circumstances arising subsequent to the date of my application for membership and privileges:

- ❖ Revocation, suspension, or voluntary relinquishment of my professional license or DEA number;
- ❖ Imposition of terms of probation or limitation imposed by any state licensing agency, including and stipulated agreement;
- ❖ Cancellation or restriction of my professional liability insurance coverage;
- ❖ Denial, loss, restriction of staff membership or privileges at any hospital or healthcare institution;
- ❖ Investigation or the filing of charges by and officer within the Department of Health and Human Services or by any law enforcement agency or regulatory agency of the United States, the State of Arizona, or any other state;
- ❖ Denial or loss of the right to participate in any Federal or State program, including Medicare and Medicaid (AHCCCS); and
- ❖ Notice of any claim or suit alleging professional liability (malpractice) in which I have been named as a party or that involves care I provided to a patient.

I understand and agree that the above authorizations are irrevocable for a period of twenty-four (24) months from the date below. A photocopy or facsimile of this authorization is as effective as the original when so presented.

Signature

Date

Name (Please Print)