Commonwealth Healthcare Corporation
Commonwealth of the Northern Mariana Islands
1 Lower Navy Hill Road, Navy Hill, Saipan, MP 96950

CLINICAL PRIVILEGES ATTESTATION

I, _____, am submitting a request for consideration for medical staff appointment and am submitting my application for Clinical Privileges.

1. Have you been subject to any voluntary and /or involuntary restrictions, reduction in privileges, special oversight or observation, subject of an investigation, or other disciplinary action in your past participation at other institutions?

NO _____. YES_____. If yes, please provide explanation on a separate page.

2. Do you have any major health problems?

NO _____. YES_____. If yes, please provide explanation on a separate page

3. Do you currently abuse illegal drugs or alcohol or controlled substances or have you done so in the past?

NO _____. YES_____. If yes, please provide explanation on a separate page.

4. Have you ever been terminated or suspended for questionable or overt unethical behavior?

NO _____. YES_____. If yes, please provide explanation on a separate page

5. Have you been the subject of any type of complaints, incident reports, or allegations related to care or conduct?

NO _____. YES_____. If yes, please provide explanation on a separate page.

5. Have you ever been terminated from employment or had privileges revoked or suspended because of negligence in performance of your duties or staff membership?

NO _____. YES_____. If yes, please provide explanation on a separate page.

6. Have you ever resigned in lieu of termination?

NO _____. YES_____. If yes, please provide explanation on a separate page

7. Have you ever been convicted of a felony or criminal offense?

NO _____. YES_____. If yes, please provide explanation on a separate page.

I certify that all information provided by me in my application is true, correct, and complete to the best of my knowledge and belief, and that the documents provided for the purpose of credentialing and privileges being requested are accurate and I have the competencies necessary to perform those privileges, and that I will notify the Commonwealth Healthcare Corporation and its Agent within 5 business days of any material changes to the information I have provided in my application or authorized to be released pursuant to the credentialing process.

I understand that corrections to the application are permitted at any time prior to a determination of Medical Staff Membership and must be submitted on-line or in writing, and must be dated and signed. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration, denial or revocation of Clinical Privileges, and/or immediate suspension or termination of Participation.

I agree and acknowledge that I have voluntarily provided all requested information, and further acknowledge that I have read and understand the foregoing Authorization of Release of Information. I understand and agree that a facsimile or photocopy of this Privilege Application and Authorization of Release of Information shall be as effective as the original.

I understand and agree, as part of the credentialing application process for Medical Staff Membership and Clinical Privileges (hereinafter, referred to as Privilege and Proctoring Application Form), I am required to provide sufficient and accurate information for proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and another criteria used by the Commonwealth Healthcare Corporation for determining initial and ongoing eligibility for participation.

I acknowledge that the Commonwealth Healthcare Corporation has its own criteria for acceptance and I may be accepted or rejected. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that clinical privileges or contract acceptance will be granted.

I consent to appear for an interview with representatives of the medical staff, hospital administration or governing body, if required or requested. As a medical staff member, I pledge to provide continuous care for my patients and I agree that I will be bound by the medical staff bylaws, rules and regulations and policies.

Signature of Physician Applicant: _____**Date**: _____