OSF HEALTHCARE
APPLICANT'S ATTESTATION

In making application for membership to the medical/professional staff membership and/or clinical privileges for initial appointment or reappointment at an OSF Healthcare System facility and/or credentialing or recredentialing for participation in the OSF Direct Access Network, I hereby certify that the information submitted by me is true to the best of my knowledge and belief. I understand that any misstatement in or omission from my application which OSF Healthcare determines in its sole discretion is material or significant may be cause for denial of the application for membership or dismissal from the Medical (Professional) Staff, termination of clinical privileges and/or denial of the application for participation in and/or dismissal from the OSF Direct Access Network.

I acknowledge that I have the burden of producing adequate information for proper evaluation of my professional training, experience, competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

I acknowledge that as an initial applicant, I have received current copies of the Medical (Professional) Staff Bylaws, Rules and Regulations, and Ethical and Religious Directives for Catholic Health Care Services and at reappointment current copies of these documents are available to me in the Medical Staff Office, if applicable.

I acknowledge that appointment/reappointment for membership and/or clinical privileges and/or credentialing/recredentialing to the OSF Direct Access Network carries with it all the responsibilities and privileges which are set forth in the Bylaws and/or contract (including the obligations to provide continuous care to my patients and to release OSF Healthcare, all its entities and those individuals participating in evaluating my qualifications from civil liability), Rules and Regulations, and policies of the Medical (Professional) Staff, hospital policies, and Ethical and Religious Directives for Catholic Health Care Services or contract, and I agree to abide by the provisions of these documents. If appointed/reappointed for membership and/or clinical privileges I agree to accept and fulfill committee assignments and such other duties and responsibilities as shall be assigned to me by the Medical (Professional) Staff. I am familiar with the principles and standards of the Joint Commission, the laws, rules and regulations, and the principles, standards and ethics of the national, state and local associations that apply to and govern my specialty and/or profession, and I agree to be bound by the terms thereof if my application for appointment or reappointment for membership and/or clinical privileges is granted.

I acknowledge and agree that I will provide any corrections, updates, and modifications to my credentials data to ensure that all credentials data remain current until final action has been taken on my application and thereafter if my application is granted. I will provide such corrections, updates, and modifications within five business days while my application is being processed. If my application is granted, I will provide such corrections, updates, and modifications within five business days for the following: State health care professional license revocation, federal Drug Enforcement Administration registration revocation, Medicare or Medicaid sanctions, revocation of hospital privileges, any lapse in professional liability coverage required under the Medical (Professional) Staff Bylaws, or conviction of a felony. For all other information, I will provide such corrections, updates, and modification within 45 days of discovering the change.

If applying for participation in the OSF Direct Access Network you have the right to check the status of your credentialing/recredentialing application. Please contact OSF DAN if you have any questions.

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Print or Type Applicant's Name

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Applicant's Legal Signature Date