

**CAROLINAS HEALTHCARE SYSTEM**

**ALLIED HEALTH PROFESSIONAL - DEPENDENT PRACTITIONER (NURSE PRACTITIONER/NURSE  
MIDWIFE/PHYSICIAN ASSISTANT/PERFUSIONIST/CERTIFIED REGISTERED NURSE  
ANESTHETIST/REGISTERED NURSE-FIRST ASSISTANT)**

**ALLIED HEALTH PROFESSIONAL - INDEPENDENT PRACTITIONER  
(PODIATRIST/PSYCHOLOGIST)**

**CONSENT AND RELEASE**

I, the undersigned, hereby apply for appointment and privileges as a Dependent Practitioner (Nurse Practitioner, Nurse Midwife, Physician Assistant, Perfusionist, Certified Registered Nurse Anesthetist, or Registered Nurse-First Assistant) or Independent Practitioner (Podiatrist or Psychologist) as indicated on the attached Application for Clinical Privileges. I am willing to make myself available for interviews in regard to this application.

I understand that as an applicant for Allied Health Professional clinical privileges, I have the burden of producing adequate information for proper evaluation of my application and that failure to produce this information will prevent my application from being evaluated and acted upon.

By applying for Allied Health Professional clinical privileges, I expressly accept the following conditions during the processing and consideration of my application, regardless of whether or not I am granted such privileges:

- (A) **IMMUNITY:** To the fullest extent permitted by law, I expressly extend absolute immunity to and release the hospital(s) and its authorized representatives and any third party from any and all civil liability arising from any acts, communications, reports, recommendations, or disclosures, including otherwise confidential information concerning me, performed, made or received in good faith, by this hospital(s) and its authorized representatives, to, by or from any third party anywhere, at any time, concerning activities relating to, but not limited to: (1) application for appointment, renewal of clinical privileges, including temporary privileges; (2) periodic reappraisals undertaken for reappointment or for increase or decrease in privileges; (3) proceedings for suspension; reduction of clinical privileges or revocation of privileges; (4) summary suspension; (5) hearings; (6) medical care evaluations; (7) utilization reviews; (8) other hospital and medical staff service or committee activities relating to the quality of patient care or to my professional conduct and concerning matters or inquiries relating to my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any affect on my professional competence, on patient care, or on the orderly operation of this or any other hospital, health care facility or institution.
- (B) **AUTHORIZATION TO OBTAIN INFORMATION:** The hospital(s) and its authorized representatives are specifically authorized to consult with the management and members of the medical staffs of other hospitals, health care facilities, or institutions with which I have been associated, and with others who may have information bearing on professional qualifications, credentials, clinical competence, privileges requested or presently granted, character, mental or emotional stability, physical condition, ethics, behavior or any other matter, as well as to inspect all records and documents that may be material to such questions. The applicant or appointee grants immunity to any and all hospitals, health care facilities, individuals, institutions, organizations and their authorized representatives who in good faith supply oral or written information, records or documents to the hospital in response to an inquiry emanating from this hospital or its authorized representatives.
- (C) **AUTHORIZATION TO RELEASE INFORMATION:** I specifically release from any and all civil liability all authorized representatives of the hospital(s), or any third party, for statements made, materials provided or acts performed in good faith in evaluating me for any purpose or reason set forth above.



(D) DEFINITIONS: As used herein, the term "hospital(s) and its authorized representatives" means Carolinas Medical Center, Carolinas HealthCare System Pineville, Carolinas HealthCare System University, Carolinas Rehabilitation, Carolinas HealthCare System Lincoln, Carolinas HealthCare System Union, Carolinas HealthCare System NorthEast, Stanly Regional Medical Center, Carolinas HealthCare System Anson, Carolinas HealthCare System Cleveland, Carolinas HealthCare System Kings Mountain, Union West Surgery Center, Columbus Regional Healthcare System, AnMed Health Medical Center, AnMed Health Rehabilitation Hospital, AnMed Health Women's and Children's Hospital, Bon Secours St. Frances Hospital, Cannon Memorial Hospital, Carolinas HealthCare System Blue Ridge-Morganton, Carolinas HealthCare System Blue Ridge-Valdese, Elbert Memorial Hospital, Mount Pleasant Hospital, Murphy Medical Center, Roper Hospital, St. Luke's Hospital, Scotland Memorial Hospital, Wilkes Regional Medical Center, New Hanover Regional Medical Center and Cone Health to include Alamance Regional Medical Center, Annie Penn Hospital, Behavioral Health Hospital, Moses H. Cone Hospital, Wesley Long Hospital, Women's Hospital (as applicable), the members of the Board of Commissioners of Carolinas HealthCare System and their appointed representatives, the Chief Executive Officer(s) and his subordinates or designees, the hospital's attorney and his assistants or designees, and all appointees to the medical staff(s) who have any responsibility for obtaining or evaluating my credentials and/or acting upon my application or conduct in the hospital(s) or any consultants the hospital(s) uses for this purpose. The term "third party" means all individuals, government agencies, organizations, associations, partnerships, or corporations, whether hospitals, health care facilities or not, from whom information has been requested by the hospital(s) or its authorized representatives or who have requested such information from the hospital or its authorized representatives.

(E) BURDEN OF PROVIDING INFORMATION: I shall have the burden of providing information deemed adequate by the hospital(s) for a proper evaluation of current competence, current licensure, relevant training and experience, character, ethics, and other qualifications, and/or of resolving any doubts about such qualifications.

1. I shall have the burden of providing evidence that all statements made and information given on the application are true and correct.
2. Until I have provided all information requested by the hospital(s), the application for appointment will be deemed incomplete and will not be processed. Should information provided in the initial application form change during the course of the appointment, I have the burden to provide information about such change to the Allied Health Review Committee(s) sufficient for the Allied Health Review Committees' review and assessment. If my application continues to be incomplete ninety (90) days after I have been notified of the additional information required, the application shall be deemed to be withdrawn. I have the responsibility to provide a complete application, including adequate responses from references. An incomplete application will not be processed.
3. I hereby apply for clinical privileges as requested above. I am willing to make myself available for interviews in regard to this application and intend to be legally bound by the terms of this Consent and Release during the processing and consideration of the application whether or not clinical privileges are granted. This acceptance applies throughout the term of appointment.
4. As an applicant for clinical privileges as an Allied Health Professional, I have the burden of producing adequate information so the hospital(s) can perform a proper evaluation of my qualifications. I agree to provide the hospital(s) with updated information regarding all questions on this application form, as new information becomes available. I also agree to provide the hospital(s) with additional information that the hospital(s) or one of its authorized representatives may request. Failure to produce any requested information will prevent my application from being processed.

I hereby acknowledge that Allied Health Professional clinical privileges within the confines of the hospital(s) are not a right of every Allied Health Professional who makes application for clinical privileges; that my request will be evaluated in accordance with prescribed procedures as defined in the hospital(s) and medical staff(s) bylaws, rules and regulations, policy and procedures, with particular emphasis on my professional competence and other factors set forth above in subsection (A), and that all medical staff(s) recommendations relative to my application are subject to the ultimate action of the Board of Commissioners whose decision shall be final. Renewal of clinical privileges remain contingent upon my continued demonstration of professional competence and cooperation.

I have received and had an opportunity to read a copy of the bylaws of the medical staff(s) and such hospital(s) policies and directives as are applicable to Allied Health Professionals (Dependent Practitioner/Independent Practitioner), and I specifically agree to abide by all such bylaws, policies, directives and rules and regulations as are in force during the time I am granted clinical privileges as an Allied Health Professional.

I certify that I meet the criteria for clinical privileges as outlined in the bylaws and that the information provided in the application is correct. I understand that completing this application in no way obligates the hospital(s) and or medical staff(s) to afford me clinical privileges. I fully understand and agree that a condition of this application is that any misrepresentation, misstatement, or omission from this application whether intentional or not, may be cause for automatic and immediate rejection of this application and may result in the denial of permission to practice at the hospital(s). In the event that privileges have been granted prior to the discovery of such misrepresentation, misstatement, or omission, such discovery may result in summary suspension of privileges.

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(Signature of Applicant)

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

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Printed or typed name of Applicant