Decatur County Memorial Hospital
The Quality Care You Want. Close By.

DECATUR COUNTY MEMORIAL HOSPITAL
RELEASE AND IMMUNITY

By applying for appointment and/or clinical privileges, I accept the following conditions and intend to be legally bound by them, regardless of whether or not I am granted appointment and/or clinical privileges. These conditions shall remain in effect for the duration of any term of appointment that I may be granted:

1. To the fullest extent permitted by law, I extend absolute immunity to, release from any and all liability, and agree not to sue the Hospital, its medical staff, their authorized representatives, personnel of peer review committees and appropriate third parties for any matter relating to appointment, reappointment, clinical privileges, or my qualifications for the same. This release and grant of immunity includes any actions, recommendations, reports, statements, communications, or disclosures involving me, which are made, taken, or received by the Hospital, the medical staff, their authorized representative, personnel of peer review committees or appropriate third parties.
2. I authorize the Hospital, its medical staff, their authorized representatives and personnel of peer review committees to consult with any third party who may have information bearing on my professional qualifications, credentials, clinical competence, character, health, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for initial and continued appointment to the medical staff, and to obtain any and all communications, reports, records, statements, documents recommendations or disclosures or said third parties to release the information to the Hospital, its medical staff, their authorized representatives and personnel of peer review committees upon request.
3. I understand and acknowledge that an investigative background inquiry will be made which will include but may not be limited to, an inquiry into my criminal, driving, and other records and reports. I further understand and acknowledge that as a part of their inquiry, Decatur County Memorial Hospital will request appropriate private or governmental agencies to conduct a criminal background check on me and to report the results of that background check to Decatur County Memorial Hospital. I understand that an unsatisfactory record will be grounds for unfavorable consideration or termination of clinical privileges at Decatur County Memorial Hospital.
4. I also authorize the Hospital, its medical staff, their authorized representatives and personnel of peer review committees to release such information to other hospitals, health care facilities, managed care entities, and their agents , who solicit such information for the purpose of evaluating any qualifications pursuant to a request for appointment and clinical privileges, participating provider status, or other credentialing matter.
5. I agree that the hearing and appeal procedures set forth in the Hospital's Bylaws, Rules & Regulations and Policies shall be my sole and exclusive remedy with request to any professional review action taken at the Hospital.
6. If I institute legal action against the Hospital, its medical staff, their authorized representative or personnel of the peer review committees and do not prevail, I agree to reimburse the Hospital and any medical staff members who are named in the action for all costs incurred in defending such legal action, including reasonable attorney's fees

Signature of Practitioner:_____ Date:_____

Printed Name of Practitioner:_____