

STRONG MEMORIAL HOSPITAL

STATEMENT OF ASSURANCES

If my application for membership and privileges is approved, I agree to abide by the Bylaws of the Medical Staff, and the Rules, Regulations, and Policies of Strong Memorial Hospital, the University of Rochester, and of the Clinical Services(s) to which I am appointed. I agree to observe all the ethical standards of my profession, to provide continuous care and supervision of my patients, and to accept consultation assignments when appropriate. I agree to accept committee assignments.

I agree to subject my clinical performance to, and faithfully participate in Strong Memorial Hospital's Quality Assurance programs; and I agree to hold members of the Medical Staff and other authorized representatives of the Hospital engaged in these Quality Assurance activities free of all liability for their actions performed in good faith in connection therewith.

I agree that the care of my patients will support the teaching mission of the School of Medicine and Dentistry. I and my patients will cooperate in furthering the instruction of students. I understand that the exact methods by which this is done are under the control of the Chief of each Services.

I authorize the Chief of the Service of my appointment(s), any designated reviewing committee(s), and the Strong Memorial Hospital Medical Staff Office to contact any institution or individual who may have information material to this application. I release Hospital and its staff members from any liability for acts and written or oral statements made in good faith in connection with an evaluation of this application. I release from any liability all individuals and organizations who in good faith provide the Hospital information materials to this application. I agree to appear for interviews in regard to this application if requested to do so.

I accept the obligation of informing the Hospital should my professional liability insurance coverage be canceled or should lapse and further agree to indemnify and compensate the Hospital for any damages which it may incur because of my failure to so act.

I authorize the Hospital to release information concerning me to any other hospital or professional association to which I may make application. I agree that all agreements in connection with this application shall also be fully applicable in connection with reappointment, corrective action, hearings, and other reviews or appraisals as provided for in the Bylaws of the Medical Staff or in the Rules and Regulations of the Hospital.

I have provided complete information about any malpractice claims, professional disciplinary proceedings and actions, and felony criminal convictions, and authorize inquiry into those matters. Except as noted on page 1, I am not aware of any health impairment that would adversely affect my professional performance and judgment in the management of my patients.

I agree to exhaust internal review processes prior to seeking judicial review of any adverse determination regarding my Medical Staff Membership.

I certify all information in this application is true and complete and that any misstatement or omission constitutes cause for withdrawal of privileges.

SIGNATURE

DATE _____

PLEASE PRINT NAME