**APPLICANT'S ATTESTATIONS**

In making application for appointment or reappointment to the Medical Staff or Allied Health Staff of Kendall Pointe Surgery Center (KPSC), I hereby certify that the information submitted by me as true to the best of my knowledge and belief. I understand that any misstatement in or omission from my application, which the Executive Committee determines in its sole discretion, is material or significant may be cause for denial of the application or dismissal from the Medical Staff or Allied Health Staff.

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 qualification. I acknowledge that I have received current copies of the Medical Staff Bylaws.

I acknowledge that appointment/reappointment to the Medical Staff or Allied Health Staff carries with it all the responsibilities and privileges which are set forth in the Bylaws (including the obligations to provide continuous care to my patients and to release KPSC and those individuals participating in evaluating my qualifications from civil liability). I agree to abide by the provisions of the Bylaws and associated policies and procedures of KPSC. If appointed/reappointed to the Medical Staff or Allied Health Staff I agree to accept and fulfill committee assignments and such other duties and responsibilities as shall be assigned to me by the Medical Staff or Allied Health Staff. I am familiar with the principles and standards of the law, 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 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 remains current if my application is granted. I acknowledge and agree to provide such corrections, updates and modifications within five (5) business days for State health care, professional license revocation, federal drug enforcement agency license revocation, Medicare or Medicaid sanction, revocation of hospital privileges, any lapse in professional liability coverage required under the Medical Staff Bylaws or conviction of a felony and with 45 days for any other change in information from the date I know of the change.

A copy of this original statement as signed by me shall have all the same force and effect as the signed original.

______________________________
Printed Name of Applicant

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Applicant's Signature Date