PAMC Attestation and Consent & Release from Liability
For Medical Students, Allied Health Professional Students and Medical Residents

PROVIDENCE Alaska Medical Center

I hereby apply to participate in training and education opportunities approved by the Medical Staff of Providence Alaska Medical Center. In return for my application being considered, I agree to be legally bound to the terms and conditions listed below.

I also understand that in applying for this training and education experience I have the burden of producing adequate information for proper evaluation of my application. I agree to provide the hospital with updated and current information regarding all questions on this application form as such information becomes available and the hospital or its authorized representatives may request such additional information as necessary. I understand failure to produce information as requested will prevent my application form being evaluated and acted upon.

By applying for this training and education opportunity, I accept the following conditions and intend to be legally bound by them, regardless of whether or not I am granted the opportunity requested. These conditions shall remain in effect for the duration of any term of a rotation that I may be granted, and as applicable to third-party inquiries received after I leave PAMC:

4. To the fullest extent permitted by law, I extend immunity to, release from any and all liability, and agree not to sue the Medical Center, its medical staff, their authorized representatives, and appropriate third parties for any matter relating to appointment, reappointment, clinical privileges or my qualifications for the same. This includes any actions, recommendations, reports, statements, communications, or disclosures involving me, which are made, taken, or received by the Medical Center, the medical staff, their authorized representatives, or appropriate third parties.

5. I authorize the Medical Center, its medical staff, and their authorized representatives (i) to consult with any third party who may have information bearing on my professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for this training and education experience and (ii) to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of said third parties that may be relevant to such questions. In addition, I specifically authorize these third parties to release the information to the Medical Center, its medical staff, and their authorized representatives upon request.

6. I also authorize the Medical Center, its medical staff, and their authorized representatives to release such information to other hospitals, health care facilities, managed care entities, and their agents, and any government or regulatory agencies, including licensure boards who solicit such information for the purpose of evaluating my qualifications pursuant to a request for training, appointment and/or clinical privileges, participating provider status, other credentialing matter, or licensure or regulatory matter.

I acknowledge that (1) a training and education experience at this hospital is not a right of every medical/AHP student who makes application for the same; (2) my request will be evaluated in accordance with prescribed procedures defined in the hospital and medical staff bylaws, rules and regulations and policies and procedures; (3) all medical staff recommendations relative to my application are subject to the ultimate action of the hospital Board of Directors, whose decision shall be final; (4) I have the responsibility to keep this application current by informing the hospital, through the CEO and/or his designee of any change in the areas of inquiry contained here in, including but not limited to any change in my professional liability insurance coverage, the filing of a lawsuit against me and any change in my medical/AHP student status at my training program; and (6) this and future training and education experiences at PAMC remain contingent upon my continued demonstration of professional competence and cooperation, my general support of the hospital, as evidenced by treatment and continuous care for patients and maintaining appropriate physician supervision during this training and education experience. I agree that I will provide acceptable performance of all responsibilities related thereto as well as the other factors deemed relevant by the hospital.

If granted this training and education experience, I specifically agree to: (1) refrain from fee splitting or other inducements relating to patient referral, (2) refrain from delegating responsibility for diagnoses or care of hospitalized patients to any other practitioner who is not credentialed to undertake the responsibility; (3) refrain from deceiving patients as to the identify of any practitioner providing treatment or services; (4) seek consultation whenever required or necessary; (5) abide by generally recognized ethical principles applicable to my profession; (6) provide continuous care as needed to all patients assigned to me through my supervising physician in the hospital for whom I have responsibility.

I represent that all of the information provided in or attached to this application is accurate and complete

Photocopies and/ or facsimile copies of this Authorization will serve the same purpose as the originally executed document.

Electronic Signature:	Date & Time Electronic Signature Authenticated:	This document has been signed with an electronic signature that was authenticated through the application process by the practitioner who answered two questions to confirm their identity.

(Stamped or representative signatures unacceptable)