

The University of Iowa Hospitals and Clinics

AUTHORIZATION TO RELEASE INFORMATION

By applying for clinical privileges, I hereby authorize University of Iowa Hospitals and Clinics, its clinical staff and their representatives to consult with members of the administration and of the medical staffs of other hospitals or institutions with which I've been associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by the hospital, its clinical staff and their representatives of all records and documents, including medical records at other hospitals and queries made to the National Practitioner Data Bank, that may be material to an evaluation of my professional qualifications and competence, as well as my moral and ethical qualifications, to carry out the clinical privileges requested. I hereby release from liability the hospital, its clinical staff, and all representatives of the hospital and its clinical staff for their acts performed without malice in connection with evaluating my application and my credentials and qualifications. I hereby release from any liability any and all individuals and organizations who provide information to the hospital or to members of its clinical staff, without malice, concerning my professional competence, ethics, character and other qualifications for clinical privileges, and I hereby consent to the release of such information.

In making this application for clinical privileges, I acknowledge that I have received and read the Bylaws, Rules and Regulations of the University of Iowa Hospitals and Clinics and Its Clinical Staff, and I agree to be bound by the terms thereof without regard to whether or not I am granted clinical privileges in all matters relating to the consideration of my application for clinical privileges. I agree to abide by the directives of the Hospital Advisory Committee and the rules and regulations of each Clinical Service in which I am granted clinical privileges. I also pledge to provide or arrange for continuous care of my patients.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

I understand and agree that any significant misstatements in or omissions from this application, including the attached curriculum vitae, shall constitute cause for denial of clinical privileges or summary suspension of clinical privileges. All information submitted by me in this application, including the attached curriculum vitae, is true to the best of my knowledge and belief.

The University of Iowa Hospitals and Clinics requests this information for the purpose of reviewing applications for clinical privileges. No persons outside the UIHC are routinely provided this information without your consent. If you fail to provide the required information, your application for clinical privileges may not be approved.

Signature of Applicant

Date

(Must be signed and dated in Black Ink)

**DEPARTMENT OF FAMILY MEDICINE
DELINEATION OF CLINICAL PRIVILEGES**

INITIAL

MODIFIED

Name: _____

I hereby apply for the following clinical privileges in the Family Medicine Clinical Service (*Check applicable boxes*):

FULL CLINICAL PRIVILEGES TO PROVIDE ANY SERVICES OFFERED BY THE FAMILY MEDICINE CLINICAL SERVICE, WITH THE FOLLOWING EXCEPTIONS AND/OR CONDITIONS (if none, write "none"):

THE LIMITED SPECIFIC PRIVILEGES: _____

THE ADDITIONAL SPECIFIC PRIVILEGES:* _____

* Please specify the additional training, experience and/or certification attained to meet the "Standards for Demonstration of Specialized Expertise," associated with the requested "Additional Specific Privileges." (Use attachment if additional space is needed).

Applicant's Signature

Date

- This applicant's appointment to the faculty of the College of Medicine has been approved and arrangements have been made for adding this applicant to the Professional Liability Insurance Policy of the Medical Service Plan. ____ Yes ____ No (If no, please explain on back of this form.)
- I recommend the approval of this application. This applicant demonstrates the health status, professional performance, judgment and clinical/technical skills necessary to exercise the above clinical privileges. (If for initial privileges, fill in the following:)

I designate _____ as observer during the period of provisional status.**

Clinical Service Head

Date

The Credentials Panel (Medical) recommends approval of this application/modification.

Chairman of Credentials Panel (Medical)

Date

The clinical privileges listed above were granted by the University Hospital Advisory Committee on _____ (date), subject to the conditions specified in the Bylaws, Rules and Regulations of the University of Iowa Hospitals and Clinics and Its Clinical Staff.

Chairman, University Hospital Advisory Committee

Date

**All initial privileges on the active clinical staff are provisional for the first three months after appointment.