HealthPLUS+

ATTESTATION

Authorization: I specifically authorize Health Plus, Inc., and its authorized representatives to consult with any third party who may have information bearing on my professional qualifications, licensure, credentials, clinical, competence, character, mental or emotional stability, physical condition, ethics, behavioror any other matter, as well as to inspect or obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of said third parties. Ispecifically authorize said third parties to release said information to Health Plus and its authorized representatives upon request. I further authorize a review of my application and credentialing file by managed care organizations for the purpose of assessing Health Plus for delegation of credentialing.

To the fullest extent permitted by law, I extend absolute immunity to, and release and hold harmless from any and all liability, Health Plus and its authorized representatives and any third party for any acts, communications, reports, records, statements, documents, recommendations or disclosures involving me, performed, made, requested, or received by Health Plus and its authorized representatives to, from, or by any third party, including otherwise privileged or confidential information made or given in good faith.

I also certify that the information given in or attached to this application is complete, accurate, and fairly represents the current level of my training, experience, capability and competence to practice. I further understand that any misrepresentations, misstatement in, or omission from this application whether intentional or not, shall of itself alone, constitute cause for automatic and immediate rejection of this application. In the event this application is approved prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in termination for cause of any agreement made as a result of this application by and between Health Plus and myself.

I agree to notify Health Plus immediately with respect to any of the following involving myself or any individual provider of health care services employed or retained under contract by myself; (i) any inquiry, investigation, action or proceeding with respectto licenses, Drug Enforcement Act registration or any change in certification or accreditation by any association or organization; (ii) any claim, notice of claim or legal action filed or threatened in connection with the rendering of health care services; (iii) any adverse malpractice judgments; and (iv) any inquiry, investigation, action or proceeding with respect to participation in any government program as a provider of health care services, including but not limited to Medicare, Medicaid, Maternal and Child Health Services Block Grant and Block Grants to States for Social Services programs.

Date:_____ Signature:_____

_____
Printed Name