Attestation Statement
(IMPORTANT: Submit Original Only)

This application is to be signed by each individual provider submitting an application.

Fill in each space with the name of the Health Plan for which you are applying.

No Stamps or Copies Please

All information submitted by me in this application, as well as any attachments or supplemental information, is true, current, and complete to my best knowledge and belief as of this date of signature below. I fully understand that any significant misstatement in this application may constitute cause for denial of my application or termination of a resulting participation agreement.

By application for membership in **RPN,** I signify my willingness to appear for interview in regard to my application. I authorize **RPN** to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been associated and with others, including past and present malpractice carries, who may have information bearing on the questions in this application. Upon request, I will obtain and provide to **RPN** materials pertaining to my qualifications and competence, including, Materials relating to complaints filed, any disciplinary action, suspension, or action to curtail my medical-surgical privileges. I further consent to the inspection by representatives of **RPN** of all documents that may be material to an evaluation of my professional qualifications and competence.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation for my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications. I release from liability all representatives of **RPN** for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability, all individuals and organizations that provide information to **RPN** in good faith and without malice concerning this application and I hereby consent to the release and verification of information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges to **RPN**.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, **RPN**, may report the rejection to the appropriate state licensing board and/or National Provider Data Bank. In the event I am accepted for participation in **RPN**, I hereby consent to **RPN** for inspection of my patient records relating to **RPN** enrollees as necessary for its peer and utilization review purposes as permitted by state or federal law and regulation I further agree to notify **RPN** in a timely manner (not to exceed 30 days) of any changes to the information on the initial application.

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PRINT NAME OF PROVIDER

_____

SIGNATURE OF PROVIDER

_____

DATE