APPLICATION FOR REAPPOINTMENT TO THE MEDICAL STAFF
ELMHURST OUTPATIENT SURGERY CENTER

Please complete this reappointment form, as well as the State of Illinois Recredentialing Gathering Form (Chapter A only). Please do not return until all questions are answered completely and attachments are enclosed.

Do you wish to remain a member of the Medical Staff at the Elmhurst Outpatient Surgery Center?
____ Yes ____ No

If "No," do not complete this form. Sign and return to discontinue your staff privileges.
If "Yes," please complete this form and return it to the Elmhurst Outpatient Surgery Center as soon as possible.

Demographic/Professional Data:

Name:_____ Specialty _____

Practice Update:

Type of Practice:

_____ Solo _____ Partnership
_____ Single Specialty Group
_____ Multi-Specialty Group
_____ Specialty
_____ Other

Name of Partnership(s): _____
Name of Group _____

ELMHURST OUTPATIENT SURGERY CENTER, LLC

In applying for reappointment to the Medical Staff of the Elmhurst Outpatient Surgery Center, I certify that I am in good health, and have the physical and mental capabilities to carry out my duties and responsibilities as a member of the Medical Staff. I agree that I will, at all times, abide by the Medical Staff By-Laws, Rules and Regulations of the Medical Staff. All information submitted by me in this application is true to the best of my knowledge and belief. In consideration of the Facility, I hereby release from any end all liability all representatives of the Facility and Medical Staff for any and all of their acts or statements at any time performed or communicated in good faith and without malice in connection with evaluating this application and my credentials and qualifications, and I hereby release from liability to the same extent any and all individuals and organizations who provide information to the Facility or its Medical Staff, to other medical, dental, podiatric associations and other interested persons on request regarding any information the Facility and Medical Staff may have concerning me as long as such release of information is done in good faith and without malice, and I hereby release from liability this Facility and Medical Staff for so doing. I further agree to report any changes in health status that would impact my ability to practice my profession at the Elmhurst Outpatient Surgery Center, and will submit to a medical and/or psychological examination deemed acceptable by the Clinical Review Committee.

_____ _____

Signature Date