CHG Healthcare RNnetwork. CompHealth. Weatherby HEALTHCARE

AUTHORIZATION & RELEASE FORM

AUTHORIZATION TO INVESTIGATE

I authorize CHG Management, Inc., its parent, subsidiary, and affiliated companies (including specifically CHG Medical Staffing, Inc. dba RN Network, Weatherby Medical Staffing, and CompHealth Allied), including any successors (collectively, "CHG"), to obtain any information that may be relevant to evaluate my professional qualifications, ability, and character, including but not limited to information about disciplinary actions or other confidential or privileged information from any source deemed appropriate by CHG.

AUTHORIZATION FOR THIRD PARTY DISCLOSURE TO CHG

I authorize any third party, including but not limited to individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement, state or national licensing boards, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical associations or societies, the Drug Enforcement Agency, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to CHG, information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my professional qualifications. I further authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based on this authorization.

AUTHORIZATION TO CHG TO DISCLOSE

I agree, understand, and acknowledge that CHG may disclose any information about me to any parent, subsidiary, or affiliated company. I agree to provide and hereby authorize the dissemination by CHG to former, current, and prospective CHG clients of the following: a) vaccination records; b) reasonable documentation evidencing that I am in good health and free of communicable diseases; c) the result of and/or a copy of my criminal background check, if any; and d) the result of and/or a copy of my drug screen, if any.

RELEASE OF LIABILITY

I hereby irrevocably and forever release CHG, its officers, employees, agents, and third parties which provide or receive information regarding me, including but not limited to those individuals and entities listed above under the "AUTHORIZATION FOR THIRD PARTY DISCLOSURE" section, from any and all, known and unknown, claims, causes of action, judgments, damages, and expenses, including reasonable attorney's fees (collectively, "Claims") arising from or relating to the disclosure, provision, collection, verification, and dissemination of information about me. Further, I agree to hold CHG harmless from any and all Claims arising from or related to the collection, verification, and dissemination of credentialing information provided by me. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities.

ATTESTATION & ACKNOWLEDGEMENT

I understand that I have the burden of providing accurate and adequate information to CHG to demonstrate my qualifications. I understand that any misstatement in this form may constitute grounds for denial of referral to practice opportunities, grounds for civil damages, reporting the same to the NPDB or state licensing boards or cancellation of contract. If any material changes occur affecting my professional status, it is my obligation to notify CHG as soon as possible. I affirm that the information I have provided in this application and attachments is true, accurate, and complete and that it can be relied upon for evaluating my potential as a healthcare provider. This document is a continuing authorization until such time as I have specifically revoked the same in writing.

I understand that the decision to refer me to practice opportunities is subject to CHG's sole and absolute discretion.

I understand that any information received by CHG from third parties, including but not limited to quality evaluations, is confidential and may not be released to me without the consent of the disclosing party.

A copy of this document shall have the same effect as the original. This document shall be governed by and interpreted according to the laws of the State of Utah, without application of any conflict of laws principles.

Full Name Signature*	Date*
Yulissa Felicity Dalisay	03-07-2023

I affirm that all information given on this page is true and accurate **Initials** YD **Date** 03-07-23