North Carolina Department of Insurance

Uniform Application To Participate as a Health Care Practitioner

Note: Please send completed applications directly to the organizations with which you seek to contract.

The following application is a form approved by the North Carolina Department of Insurance, in accordance with North Carolina General Statute 58-3-230. Every insurer that provides a health benefit plan and credentials providers for its network is required to use this form and the insurer may not require an applicant to submit information that is not required by this form Only the Commissioner of Insurance is authorized to make changes, deletions or additions to this form.

A. DEMOGRAPHIC AND PERSONAL DATA:

1. Name of Applicant: ALISON (Last Name) (First Name) LEIGH (Middle Name) (Maiden)

2. Date of Birth: 07/14/1983 | Place of Birth:
Social Security Number: | Sex: Male ☐ Female ☐ Female

3. Type of Practice: Primary Care: ☐ Specialist: ☐
(Primary Specialty) | (Secondary Specialty)
Please Identify Areas of Clinical Expertise:
What population(s) do you treat (e.g. geriatric, all ages):

4. Name of Practice: Certified Registered Nurse Anesthetist (CRNA)

5. Primary Office Address (If you maintain more than one office, list each office, address, and hours of operation)

Practice Name: Certified Registered Nurse Anesthetist (CRNA)

Address:
(Street) (City) (County) (State) (Zip)

Handicapped Accessible? YES ☐ NO ■ Office Phone: Fax:

E-mail address: jnulty3@gmail.com

Accepting New Patients? YES ☐ NO ☐ Restrictions:
(Please list or indicate none)

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Secondary Office Address

Practice Name:

Address:
(Street) (City) (County) (State) (Zip)

Handicapped Accessible? YES ☐ NO ☐ Office Phone: Fax:

E-mail address:

Accepting New Patients? YES ☐ NO ☐ Restrictions:
(Please list or indicate none)

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

A. DEMOGRAPHIC AND PERSONAL DATA (Continued)

Additional Office Address or Billing Address, if different (check one) ☐ Billing ☐ Office
Name:
Address: (Street) (City) (County) (State) (Zip)
Handicapped Accessible? YES ☐ NO ☐ Office Phone: Fax:
Accepting New Patients? YES ☐ NO ☐ Restrictions: (Please list or indicate none)
Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

6. Name other provider(s) in your practice (if not enough space, please attach additional sheet):

7. Do nurse practitioners, physician assistants, midwives, social workers, or other non-physician providers provide care to patients in your practice? YES ☐ NO ☐
(If yes, please attach proof of professional liability insurance and proof of employment for those individuals)

8. Name and address of provider(s) who share call with you (if not enough space, please attach additional sheet):

Name:	Name:
Address:	Address:

9. Arrangements for 24 hour/7 day coverage:

10. Administrative Contact:
(Name) (Title) (Telephone)

11. IRS requires reimbursement be made payable to name of practice affiliated with Federal Tax ID Number:

Federal Tax ID Number:
Name (if different from practice name):
Billing Address (if different from practice address):

12.

UPIN Number:	Medicare/Medicaid Number: /
National Provider Identifier (NPI): 1487996344	

13. DEA Number: Exp. Date:
(Attach copy to application)

A. DEMOGRAPHIC AND PERSONAL DATA (Continued)

COMPLETE ONLY IF LICENSED IN SOUTH CAROLINA

SC Controlled Drug Substance Certificate: Expiration Date:
(Attach a copy to application)

14. Provide the following information for each state in which you are currently or were previously licensed to Practice (If not enough space please attach additional sheet)

STATE	DATE OF LICENSE	LICENSE NUMBER	STATUS Active, Inactive, Suspended	EXPIRATION DATE
NC	01/30/2009	229275	Active	07/31/2026

PLEASE ATTACH A COPY OF EACH STATE LICENSE CERTIFICATE

15. Certification of Specialty Boards as applicable:

a. If you are certified by a specialty board, indicate name of board and date of certificate.

Certified Registered Nurse Anesthetist (CRNA) (Primary Specialty Board)	Date Certified: 5/2/2013	Exp. Date:
(Secondary Specialty Board)	Date Certified:	Exp. Date:

b.. Are you listed in the American Board of Medical specialists? YES ☐ NO ☐

c. If you have applied to a specialty board for examination, give the name of board and the date of scheduled examination.

	Date:

d. If you have not applied to a specialty board, please explain: ☐

A. DEMOGRAPHIC AND PERSONAL DATA (Continued)

16. List the dates of all current professional memberships in societies, including state and county societies:

	FROM	TO

17. List all hospitals where you currently have privileges and indicate the type and status of those privileges:
(Type: active, admitting, associate, consulting, courtesy. Status: pending, provisional, suspended, temporary, visiting)

Hospital	Privilege and Status of Privilege	Estimated % of Admission
(primary admitting facility)		

18. If you do not have admitting privileges, who admits for you?

Name:	Name:
Address:	Address:
Phone:	Phone:

B. EDUCATION AND PRACTICE HISTORY

1.

Medical, Dental, or other Professional School Attended:		
Institution: The University of North Carolina		
Address: Greensboro, (Street) (City) (State) (Zip)		
Degree: Doctor of Nursing Practice	From:	To: 2019

Please attach Educational Commission of Foreign Medical Graduate Certificate – (ECFMG), if applicable.

2.

Internship		
Institution:		
Address: (Street) (City) (State) (Zip)		
Specialty:	From:	To:

3.

Residency		
Institution:		
Address: (Street) (City) (State) (Zip)		
Specialty:	From:	To:

4.

Other Residency / Fellowship – (specify)		
Institution:		
Address: (Street) (City) (State) (Zip)		
Specialty:	From:	To:

B. EDUCATION AND PRACTICE HISTORY (Continued)

5. List work history since beginning of medical, dental, or other professional school; please be specific. (If not enough space, please attach additional sheet)

	FROM	TO
(Current Practice) LeBauer Endoscopy Center	mm/yyyy 04/23	mm/yyyy
(Previous Practice)	mm/yyyy	mm/yyyy
(Previous Practice)	mm/yyyy	mm/yyyy
(Previous Practice)	mm/yyyy	mm/yyyy
(Previous Practice)	mm/yyyy	mm/yyyy

6. List other training and/or education (including CME) within the last three years, if applicable.

7. Have you involuntarily or voluntarily withdrawn or been suspended from any internship, residency or fellowship training program? Please explain:

8. Please explain any incident(s) in which you have involuntarily or voluntarily withdrawn your application for appointment, clinical privileges or reappointment before a decision was made by a hospital or healthcare facility's governing board.

C. PROFESSIONAL INFORMATION

Please check yes or no for the following questions. Please complete the attached Supplemental Form for any questions to which you answer "yes". Also please sign and date this application. If this application does not have the provider's signature, it cannot be accepted.

1.	Has your license to practice in any jurisdiction ever been limited, restricted, reduced, suspended, voluntarily surrendered, revoked, denied or not renewed; have you ever been reprimanded by a state licensing agency; or are any of these actions pending with respect to your license; are you under investigation by any licensing or regulatory agency? (If yes, please complete Supplemental Question No. 1.)	Y ☐	N ☐
2.	Has your professional employment or membership in a professional organization ever been subject to disciplinary proceedings, denied, limited, restricted, reduced, suspended, revoked, not renewed, or voluntarily relinquished during or under threat of termination for any reason? (If yes, please complete Supplemental Question No.2.)	Y ☐	N ☐
3.	Has your Drug Enforcement Agency registration or other controlled substance authorization ever been limited, restricted, reduced, suspended, revoked, denied, not renewed, or have you voluntarily surrendered or limited your registration during or under the threat of an investigation or are any such actions pending? (If yes, please complete Supplemental Question No.3.)	Y ☐	N ☐
4.	Have you ever been sanctioned or suspended by Medicare or Medicaid? (If yes, please complete Supplemental Question No.4.)	Y ☐	N ☐
5.	To your knowledge, have you ever been reported to the National Practitioner Data Bank or the North/South Carolina Board of Medical Examiners? (If yes, please complete Supplemental Question No.5.)	Y ☐	N ☐
6.	Have you ever been convicted of a felony or misdemeanor, or are you under investigation with respect to such conduct? (If yes, please complete Supplemental Question No.6.)	Y ☐	N ☐
7.	Has a professional liability claim been assessed against you in the past five years, or are there any professional liability cases pending against you? (If yes, please complete Supplemental Question No.7.)	Y ☐	N ☐
8.	Has any liability insurance carrier canceled, refused coverage, or rated up because of unusual risk or have any procedures been excluded from your coverage? (If yes, please complete Supplemental Question No. 8.)	Y ☐	N ☐
9.	Have you ever practiced without liability coverage? (If yes, please complete Supplemental Question No.9.)	Y ☐	N ☐
10.	Do you currently have any medical, chemical dependency or psychiatric conditions that might adversely affect your ability to practice medicine or surgery or to perform the essential functions of your position? (If yes, please complete Supplemental Question No.10.)	Y ☐	N ☐
11.	Have your Hospital and/or Clinic privileges ever been limited, restricted, reduced, suspended, revoked, denied, not renewed, or have you voluntarily surrendered or limited your privileges during or under the threat of an investigation or are any such actions pending? (If yes, please complete Supplemental Question No. 11).	Y ☐	N ☐

SUPPLEMENTAL FORM

Provider Name:	Provider ID# (if applicable)

1. License Limited, Reprimanded, etc.

List State(s) where action took place:
Date(s) License revoked, suspended, etc. From xx/xx/xxxx To xx/xx/xxxx
Please explain:

2. Employment/Membership Suspended, Limited, etc.

List State(s) where action took place:
List Professional Organization:
Please explain:

3. Drug Enforcement Agency (DEA) Explanation.

List State(s) where action took place:
Please explain:

SUPPLEMENTAL FORM

Provider Name:	Provider ID# (if applicable)

4. Medicare/Medicaid Sanction Disciplinary Action(s)

Disciplined Action(s):
List State(s):
Date(s) of action. From xx/xx/xxxx To xx/xx/xxxx
Please explain:

5. National Practitioner Data Bank Report(s)

Please explain the NPDB report (if you have a copy please attach):

6. Felony or Misdemeanor

Did you serve a sentence: Y ☐ N ☐ If YES, check how many years: 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ Other:
List State(s):
Please explain charge and verdict:

SUPPLEMENTAL FORM

Provider Name:	Provider ID# (if applicable)

7. Named in Professional Liability Judgment, Settlement, etc.

Please explain, include dates & amounts:

8. Cancelled, Refused Coverage, etc.

Please list Insurance Carrier(s):
Please explain:

9. Practiced Without Liability Coverage

Please explain:

SUPPLEMENTAL FORM

Provider Name:	Provider ID# (if applicable)

10. Medical, Chemical Dependency, or Psychiatric Conditions

Please explain in detail:

11. Hospital or Clinic Privileges Revoked, Restricted, etc.

List Hospital(s):
Date privileges revoked, suspended, etc. From xx/xx/xxxx To xx/xx/xxxx
Please explain:

APPLICATION ADDENDUM

Demographic Information:

Home Address: NC, Greensboro, 27401
Street City Zip

e-mail: alisonlcarver@hotmail.com

Home Telephone: _____ Pager: _____

Mobile: 919-600-2424 Answering Service: _____

Preferred Contact Method: provider

Numbers acceptable for publication within the hospital: ☐ Office ☐ Home ☐ Pager ☐ Mobile

Marital Status: ☐ Single ☐ Divorced ☐ Married; Spouse's Name: _____

Citizenship: Are you a citizen of the USA? ☐ Yes ☐ No

If no, in what country do you retain citizenship? provider ***Please provide a copy of your current visa**

*If you are bilingual, would you like to serve as a medical interpreter? ☐ Yes ☐ No

Advanced Practice Provider Location: ***Please select the appropriate campus.**

☐ **Alamance Regional Medical Center:**

☐ **Cone Health:**

(Annie Penn Hospital, Behavioral Health Hospital, Moses Cone Hospital, Wesley Long Hospital, Women's Hospital)

Board Certification: Are you currently Board Certified? ☐ Yes ☐ No

If yes, please provide the name of the Board(s) and certification date(s): _____

If no,

1. Have you previously taken the exam? ☐ Yes ☐ No, please explain:
2. Are you currently eligible to take the exam? ☐ Yes ☐ No, please explain:
3. When do you plan to sit for the examination? _____

Do you keep a copy of your collaborative/supervisory agreement at each practice location? ☐ Yes ☐ No

***For the ARMC campus: All applicants must have national certification applicable to their profession and field of practice Continual maintenance of Board Certification is required. (ARMC Bylaws, 5.1.1)**

***For the Annie Penn Hospital, Behavioral Health Hospital, Moses Cone Hospital, Wesley Long Hospital, and Women's Hospital: All applicants must have national certification applicable to their profession and field of practice. (Cone Health Medical and Dental Staff Rules and Regulations, 1.2.**

Medical Information:

***If the answer to any of the questions below is "Yes," please give full details on a separate sheet**

1.	Do you currently have, or have you ever had, any health impairment (including alcohol or drug dependency, and/or admission to, or participation in any alcohol or drug rehabilitation program) physical or mental disabilities, which reasonably might affect your ability to practice such clinical privileges requested, with the generally recognized professional level of quality, efficiency, and continuity, noting that any grant of clinical privileges, for initial appointment or reappointment, may be conditioned upon examinations? If yes, please provide details, including information regarding your treatment and the name of your treating physician, on a separate sheet.	☐ Yes ☐ No
2.	Have you been hospitalized within the past five years?	☐ Yes ☐ No
3.	Have your privileges ever been modified, qualified, or suspended at any hospital or health care institution because of a health problem?	☐ Yes ☐ No
4.	Have you voluntarily or involuntarily had your practice/procedures/clinical privileges eliminated, modified, or restricted as a result of an investigation or any other activity of any regulatory body concerned with public health, disease or infection control, or the practice of medicine, dentistry, podiatry or related regulated activities, including the issuance of any temporary or permanent isolation order by the State Health Director or his designee?	☐ Yes ☐ No
5.	Are you currently taking any medication that may affect either your clinical judgment or motor skills?	☐ Yes ☐ No

I attest that I am not aware of any physical, mental or emotional conditions that could affect my ability to perform all or any of my requested privileges in my specialty area or that would require an accommodation to perform these privileges safely and competently.

Signature _____ Date _____

Do you have ownership or control interest of 5% or more in this organization? ☐ **Yes** ☐ **No**

Have you completed cultural competency training? ☐ **Yes** ☐ **No**

Malpractice Insurance:

***Please attach a copy of your current medical malpractice certificate ($1,000,000 - $3,000,000 minimum limits)**

Are you currently covered under an Extended Reporting Endorsement (tail coverage) for any previous Claims Made policy?

PROFESSIONAL LIABILITY INSURANCE **(For the past ten years, please use a separate sheet if necessary)**

1. Insurance Carrier: _____

Address: 1200 North Elm Street City: Greensboro State: NC Zip: 27401

Phone: _____ Fax: _____

Policy Number: _____ Expiration Date: _____

2. Insurance Carrier: AANA Insurance Services

Address: 10275 West Higgins Road, Suite 500 City: Rosemont State: IL Zip: 60018

Phone: _____ Fax: _____

Policy Number: _____ Expiration Date: 4/13/2025

PREVIOUS AFFILIATIONS: *This information must be completed regardless of prior duplication.*

Please list in chronological order all **previous** institutional/practice affiliations, teaching appointments or military service since the completion of your postgraduate education. Complete addresses, email and/or fax numbers must be included. If more space is needed, attach an additional sheet.

If the foregoing chronology does not account for all time periods since the completion of your postgraduate education, please describe your whereabouts and/or activities during such periods. Any gaps in education, professional employment, etc. must be accompanied by an explanation.

Institution/Practice Name: CRNA, Wesley Long Hospital **Type of Privileges:** _____

Mailing Address: _____

Fax: _____ **e-mail:** _____

Contact Name (if available): _____ **Dates of Appointment from:** _____ **to:** _____

Institution/Practice Name: Cone Health **Type of Privileges:** _____

Mailing Address: _____

Fax: _____ **e-mail:** _____

Contact Name (if available): _____ **Dates of Appointment from:** _____ **to:** _____

Institution/Practice Name: Womenâ€™s Hospital of Greensboro **Type of Privileges:** _____

Mailing Address: _____

Fax: _____ **e-mail:** _____

Contact Name (if available): _____ **Dates of Appointment from:** _____ **to:** _____

Institution/Practice Name: East Carolina Anesthesia Associates **Type of Privileges:** _____

Mailing Address: _____

Fax: _____ **e-mail:** _____

Contact Name (if available): _____ **Dates of Appointment from:** _____ **to:** _____

Institution/Practice Name: _____ **Type of Privileges:** _____

Mailing Address: _____

Fax: _____ **e-mail:** _____

Contact Name (if available): _____ **Dates of Appointment from:** _____ **to:** _____

PROFESSIONAL REFERENCES:

Name at least **four (4)** peer references that have recently and directly observed your **current** professional performance including, but not limited to your clinical ability, competence, knowledge, and judgment; ethical character; health status; interpersonal and communication skills; and, professionalism. The definition of a peer is someone from the same/similar professional discipline as the Practitioner applying for clinical privileges.

Please include a supervising physician, Department Chair, Chief of Service or VPMA/CMO as one of the references. If you have just completed your residency or fellowship, please list the Program Director as one of the references.

The undersigned understands that the references listed will be asked to respond to a professional reference questionnaire with specific questions relating to the above.

1. Name: Dr. Robert _____ Title: _____

   Group/Practice/Affiliation: Anesthesiologist, _____

   Address: _____
   Street City State Zip

   Fax: _____ e-mail: rfitzgerald@acnchealth.com

2. Name: Suzanne _____ Title: _____

   Group/Practice/Affiliation: CRNA _____

   Address: _____
   Street City State Zip

   Fax: _____ e-mail: suzig9999@gmail.com

3. Name: _____ Title: _____

   Group/Practice/Affiliation: _____

   Address: _____
   Street City State Zip

   Fax: _____ e-mail: _____

4. Name: _____ Title: _____

   Group/Practice/Affiliation: _____

   Address: _____
   Street City State Zip

   Fax: _____ e-mail: _____

Cone Health

MEDICARE ACKNOWLEDGMENT STATEMENT

IN ACCORDANCE WITH CMS GUIDELINES OUTLINED

Title: 42 CFR PART 412.46C

Notice to Physicians: Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

Signature **Date**

ALISON

Printed Name

Expectations of Physicians Granted Privileges in the Cone Health

This document describes the expectations that physicians have of each other as members of our medical staff based on the Joint Commission General Competencies framework for physicians. The expectations described below reflect current medical staff bylaws, policies and procedures and organizational policies. This document is designed to bring together the most important issues found in those documents and key concepts reflecting our medical staff's culture and vision.

Medical staff leaders will work to improve individual and aggregate medical staff performance through non-punitive approaches and providing appropriate positive and constructive feedback that allows each physician the opportunity to grow and develop in his or her capabilities to provide outstanding patient care and valuable contributions to our hospital system.

Patient Care:

Provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and at the end of life.

- Achieve patient outcomes that meet or exceed generally accepted medical staff standards as defined by comparative data and targets, medical literature, and results of peer review evaluations.
- Use sound clinical judgment based on patient information, available scientific evidence, and patient preferences, to develop and carry out patient management plans.
- Demonstrate caring and respectful behaviors when interacting with patients and their families.

Medical Knowledge:

Demonstrate knowledge of established and evolving biomedical, clinical and social services, and the application of their knowledge to patient care and the education of others.

- Use evidence-based guidelines, when available, as recommended by the appropriate specialty, in selecting the most effective and appropriate approaches to diagnosis and treatment

Practice-Based Learning:

Use scientific evidence and methods to investigate, evaluate, and improve patient care.

- Review individual and specialty data and use this data for self-improvement to continuously improve patient care.

Interpersonal/Communication Skills:

Demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of healthcare teams.

- Communicate clearly with other physicians and caregivers, patients, and patient's families through appropriate oral and written methods to ensure accurate transfer of information.
- Provide thorough and legible documentation that supports medical decision-making and treatment according to medical and national standards.

Professionalism:

Demonstrate behaviors that reflect a commitment to continued professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society.

- Act in a professional, respectful manner at all times to enhance a spirit of cooperation and mutual respect and trust among members of the patient care team.
- Respond promptly to requests for patient care needs.
- Respect patient's rights by disclosing unanticipated adverse outcomes and refrain from discussion of patient care information and issues in public settings.
- Participate in emergency room call coverage as required by medical staff policy.

Systems-Based Practice:

Demonstrate both an understanding of the contexts and systems in which healthcare is provided, and the ability to apply this knowledge to improve and optimize healthcare.

- Strive to provide cost-effective quality patient care by cooperating with efforts to manage the use of valuable patient care resources.
- Participate in the Health System's efforts and policies to maintain a patient safety culture, reduce medical errors, meet National Patient Safety Goals and improve quality.

CONE HEALTH
The Network for Exceptional Care

Release and Authorization

(Please read carefully before signing)

I hereby request application or reappointment to the medical or advanced practice provider staff and renewal of my clinical privileges as specified on the enclosed form. I understand that any significant misstatements in or omissions from this Application constitute cause for denial of appointment or reappointment or cause for dismissal from the Medical and Dental Staff. All information submitted by me in this Application is current and true to my best knowledge and belief. By applying for appointment to the Medical and Dental Staff(s), I hereby signify my willingness to appear for interviews in regard to my Application. I hereby authorize CONE HEALTH, its Medical and Dental Staff(s) and their representatives to consult with administrators and members of the medical staffs of other hospitals or institutions with which I have been associated and with others, including past and present professional liability carrier, who may have information bearing on my professional competence, character and ethical qualifications to include licensure, specific training/experience, current competence, and ability to perform the privileges requested. I hereby further consent to the inspection by CONE HEALTH, its Medical and Dental Staff(s) and their representatives of all documents, including medical records at other hospitals, that may be relevant to an evaluation of my professional qualifications, current competence and ability to carry out the clinical privileges requested, as well as my moral and ethical qualifications for Medical and Dental Staff membership. Also, I understand that my Social Security Number (SSN) will be used by CONE HEALTH representatives to obtain past education and employment verifications.

I hereby further authorize CONE HEALTH and its Medical and Dental Staff(s) to communicate with other previous employers/professional associations/other interested persons regarding any information concerning my professional competence, character and ethics that CONE HEALTH may have or acquire.

I understand and agree that I, as an applicant for Medical and Dental Staff(s) membership and/or privileges, have the burden of producing adequate information for proper evaluation of my education, training, experience, professional competence and ability, judgment, character, ethics and other qualifications and for resolving any doubts about such qualifications.

I particularly agree to subject my clinical performance to, and faithfully participate in, CONE HEALTH's quality improvement efforts as the same shall from time to time be in effect, and I agree to hold Members of the Medical and Dental Staff(s) free from all liability for their actions performed in good faith in connection therewith.

I agree that I have had access to and have been given the opportunity to read the Medical and Dental Staff(s)' Bylaws and Rules and Regulations, the Corporate Bylaws of Cone Health Operating Corporation or Alamance Regional Medical Center, Inc., and summaries of other pertinent Hospital Policies and Procedures. I agree to be bound by the foregoing if I am granted membership on the Medical and Dental Staff(s) and/or clinical privileges, and to be bound by the foregoing in all matters relating to consideration of this Application without regard to whether I am granted such membership and/or clinical privileges. I acknowledge that I have read and understood, and agree to, the broad scope and extent of authorization, confidentiality, immunity and release provisions of the Bylaws, and Dental Staff(s)' Bylaws made with respect to me, I will first exhaust any and all administrative hearing and review procedures afforded by the Medical and Dental Staff(s)' Bylaws if I desire to change or contest such decision.

I hereby release from liability all entities comprising or affiliated with CONE HEALTH, and all officers, representatives or agents of CONE HEALTH and its Medical and Dental Staff(s) for all their actions or omissions taken without malice in connection with my Application, and I hereby release from all liability any and all individuals and organizations who provide information to CONE HEALTH or its Medical and Dental Staff(s) without malice concerning my professional competence, ethics, character and other qualifications for Staff appointment and clinical privileges, and I hereby consent to the release of such information to CONE HEALTH.

I am applying for membership and/or privileges to the following Cone Health Medical and Dental Staff(s) (please specify)[√]:

☐ **Alamance Regional Medical Center** ☐ **Cone Health (Greensboro Campuses and Annie Penn)**

Signature: _____ **Date:** _____

Print Name: ALISON