

Immunity from Liability for Release of Information
Franklin Square Hospital Center

The Franklin Square Hospital Center is required by accrediting bodies to verify from original sources the extensive background which you have provided to us in your application for residency/fellowship, and to update and verify the information.

This document is a part of your application for residency/fellowship at the Franklin Square Hospital Center. Your signature is required in order that the Franklin Square Hospital Center may secure information in good faith that will enable us to make informed decisions.

Permission to Obtain Information

I give my consent and permission to Franklin Square Hospital Center, the Medical Staff members, its agents, servants, employees, to contact other hospitals and health care facilities, professional societies, medical schools, licensing bodies, professional review organizations, professional malpractice insurance carriers, named references and other individuals and organizations that the Franklin Square Hospital Center deems necessary for the purpose of inspecting all records and documents pertaining to my licensure, medical training, experience, and qualifications as listed on my application for residency/fellowship.

Release and Indemnification

I grant ABSOLUTE IMMUNITY to and full RELEASE from liability to Franklin Square Hospital Center and its Board of Directors, Medical Staff members, their agents, servants, and employees, and to each hospital, institution, physician or other person who provides information in good faith and without malice to Franklin Square Hospital Center in connection with my application or request. This immunity and release shall be applicable with respect to any and all claims which might arise from any acts, communications, reports, recommendations or disclosures involving me as an applicant or employee of the Franklin Square Hospital Center, which are performed, made, requested, or received by Franklin Square Hospital Center or any of its representatives or from any third party.

I agree to INDEMNIFY and hold the Franklin Square Hospital Center and all of its representatives and third parties harmless from any claim against them as a result of any action taken in good faith and without malice in the credentialing process, and I agree to indemnify them from all costs, claims, and expenses including reasonable attorneys' fees resulting from any claim made in connection with the credentialing process.

This RELEASE and INDEMNIFICATION shall continue in force for all matters in connection with the granting, denial, approval, reprieval, suspension

Signature: _____ Date: _____

Print Name: _____ Date: _____