Release and Authorization Information

I, _____

Last Name First Name Middle Name (Please Include JR, SR, I, III, Etc.)

hereby affirm that the information I have provided on this application and attachments is true and correct and that it can be relied upon by LocumsPro and its affiliates for evaluating my potential as a physician.

By applying for membership to, or when evaluating retention with LocumsPro, I hereby authorize LocumsPro, its affiliates and successors, to obtain any information that may be relevant to an evaluation of my professional qualifications, including but not limited to information about disciplinary actions or other confidential or privileged information, and other credentials.

I agree to provide and authorize the release by LocumsPro to LocumsPro 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 copy of my drug screen, if any.

I authorize LocumsPro to disclose to and receive from current, prior, or potential employers and LocumsPro clients making reasonable inquiry, information relating to my qualifications, ability, and character to practice medicine, including information from the following sources: all medical schools, colleges, universities, transcript offices, medical institutions, or organizations, hospitals, employers, personal references, physicians, attorneys, companies or agencies who may furnish my criminal background history, companies that perform drug screen, medical malpractice carriers or organizations, business and professional associates, all government agencies and instrumentalities, the National Practitioner Data Bank, the Federation of State Medical Boards, the American Medical Association, American Osteopathic Association, American Board of Medical Specialties, DEA, state licensing boards, Specialty boards, and any other pertinent source. This is a continuing authorization until such time as I have specifically revoked the same in writing which shall apply to all information received at any time by LocumsPro relating to my qualifications, ability, and character to practice medicine.

I hereby forever waive and release LocumsPro, its officers, employees, agents and third parties which provide or receive information regarding my credentials, including but not limited to the Federation of State Medical Boards and those entities listed above, from any claims, causes of action, damages and expenses, including reasonable attorney's fees arising from or relating to the provision, collection, verification, and dissemination of information about me.

Further, I agree to hold LocumsPro harmless from any and all claims, causes of action, damages, judgments and expenses, including reasonable attorney's fees, arising from or related to the collection, verification and dissemination of credentialing information provided by me. I understand that this does not contemplate a duty to hold LocumsPro harmless from claims, causes of action and damages which may arise as a result of information provided about me from a source other than myself. I understand that I have the burden of providing accurate and adequate information to LocumsPro, its affiliates or successors, 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, grounds for 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 LocumsPro or the appropriate affiliate or successor as soon as possible. I attest that the information contained in the application is correct and complete.

I understand that the decision to refer me to practice opportunities by LocumsPro is solely at the discretion of LocumsPro.

I understand that any information received from the references by LocumsPro, including but not limited to quality evaluations, is confidential and may not be released to me without the consent of the reference.

A copy or facsimile of this document shall have the same effect as the original.

This document shall be interpreted according to the laws of the State of Illinois.

_____ _____

Signature* Date*

_____

SSN*

*Required information