Attestation and Consent

Molina Healthcare, Inc

I affirm that all information and documentation submitted by me in this application is correct, complete, and current to my best knowledge and belief. I acknowledge that any misstatement in or omissions from this application may constitute cause for denial of my application for membership or participation. I understand and agree that, as an applicant for participation, I have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

I hereby authorize the entity to which this Application, Attestation, and Consent is being submitted to contact and/or consult with any persons, entities, or institutions which I have been affiliated, have used for liability insurance, or who may have information relevant to my character and professional competence and qualifications, whether or not such persons or institutions are listed as reference by me. I consent to the release and communication of information and documents with entities or institutions in jurisdictions in which I have been trained, resided, practiced, or applied for professional licensure, for the purpose of evaluating my professional training, experience, character, conduct, ethics and judgment, and to determine professional liability insurance and/or malpractice claims history.

I release and hold harmless from liability all persons, entities, or institutions who, in good faith and without malice for acts performed in gathering or exchanging information in this credentialing or recredentialing process. This provision applies to all persons, entities and institutions who will provide and/or receive, as a part of the credentialing process, information which may relate to my past or present physical and/or mental condition, including substance abuse, alcohol dependency, and mental health information.

I further affirm that I currently do not have any physical and/or mental conditions and/or impairments, such as substance abuse, alcohol dependency, and/or mental health concerns which interfere with my ability to practice medicine.

A copy of this original statement as signed by me shall have the same force and effect as the signed original statement.

Name (Please Print):

_____

Signature:

_____

Date:

_____