Central Credentialing Office
3535 Southern Blvd., Kettering, OH 45429
937-395-8324
937-395-8357 (FAX)

TO: **Medical Staff Member**

FROM: Melissa Walters, MHA, CPMSM, CPCS
Director, Medical Staff Services & Network Credentialing

RE: **BIENNIAL REAPPOINTMENT**

It is time for your reappointment to the Medical Staff at Kettering Medical Center and/or Sycamore Medical Center. Please follow the instructions below for completing the enclosed *Reappointment Application Packet* and submit any other information, which maybe required for your application for reappointment.

Please provide the Central Credentialing Office with any changes in office and/or home information (this includes: addresses, phone/fax/cell numbers, email, etc.

Reappointment Application Packet

- ☐ Complete and sign.
- ☐ Updated PHOTO (NO driver's license)
- ☐ Complete Annual TB Evaluation
- ☐ Complete Annual Safety Education **(download from KHN Physician's Only website)**
- ☐ Please complete the Professional Sanctions Form, if applicable.
- ☐ Please complete the Malpractice Claims Assessment form, if applicable.
- ☐ Complete and sign the Disclosure and Authorization Form.

Authorization for the Release of Information and Liability

- ☐ Sign and date.

Clinical Privilege Profile

- ☐ Download, complete, sign and date Clinical Privileges Profile for your designated hospital, specialty.
- ☐ If requesting **moderate sedation (conscious and/or procedural sedation),** please provide a current copy of your ACLS, ATLS, PhyAmerica or Airway Management course provided by Kettering Medical Center/Sycamore Medical Center or other GDAHA Hospital.
- ☐ If requesting additional privileges, please attach documentation attesting to your training and experience.

CME Hours (10 Category I for all except PEDS which requires 40hrs CMEs)

- ☐ List hours or attach documentation

Application Fee

- ☐ Be sure to enclose the appropriate non-refundable application fee (**$100 – Active and $200 – Courtesy and Associate)**, made payable to Kettering Medical Center in care of Central Credentialing Office. **A LATE FEE will be assessed per departmental policy for any application not received in a timely manner.**

Prior to submitting your packet, please review to ensure all necessary forms and documents are completed and signed. Should you have any questions, please call 937-395-8324.

REAPPOINTMENT APPLICATION PACKET

☐ **Kettering Medical Center** ☐ **Sycamore Medical Center**

(*Please mark all facilities for which you are applying)*

A. PERSONAL INFORMATION

Applicant Name : ________________________________ Applicant's Email : ___________________________________

B. PROFESSIONAL REFERENCE

Please provide one reference, preferably within your clinical specialty. This reference SHOULD NOT be your current clinical service chairperson. Reference will be evaluated according to the extent of their direct clinical observation of your work and other knowledge of you. **NOTE:** This reference must be a "peer", i.e. MD/DO to MD/DO, DPM to DPM, RN to RN, PA to PA, etc.

Name :____ Specialty :_________________________________

Address :____ Phone : _____________________________________

City, State, Zip : ___________________________________ Fax : ____

C. UPDATED PROFILE INFORMATION

Board Specialty: Board Certified ☐ Yes ☐ No (If NO, I understand that current Bylaws of KMC require that I secure board certification within six years of completion residency).

I plan on fulfilling this requirement by: ____

Applicant Signature: ____

If you have obtained board certification, re-certification or additional certification(s) within the past two years, please indicate.

Name of Board ______________________________ **Status** _________________________ **Expiration** _________________________

Name of Board ______________________________ **Status** _________________________ **Expiration** _________________________

Hospital Affiliation: Please mark ALL hospital/surgery center affiliations:

☐ Atrium Regional Hospital
☐ Children's Hospital (Dayton)
☐ Clinton Memorial
☐ Dayton Eye Surgery Center
☐ Dayton Rehab Hospital
☐ Far Hills Surgery Center
☐ Good Samaritan Hospital
☐ Good Samaritan Surgery Center
☐ Grandview/Southview Hospitals
☐ Greater Dayton Surgery Center
☐ Greene Memorial Hospital
☐ Kindred Hospital
☐ Lifecare
☐ Medical Center at Elizabeth Place
☐ Miami Valley Hospital
☐ Springfield Regional Medical Center
☐ Upper Valley Medical Center
☐ VA Medical Center (Dayton)
☐ Wayne Hospital
☐ Wilson Memorial Hospital
☐ Wright Patterson AFB
☐ Other ____
____

Please provide any additional hospital affiliations (not listed above) obtained within the past two years.

D. PROFESSIONAL SANCTIONS

Please answer each of the following questions in full. If the answer to any of the following is "YES", please complete the Professional Sanctions Reporting Form.

1. In the past two years have any disciplinary actions been initiated or are any pending against you by any state licensure board? ☐ Yes ☐ No
2. In the past two years has your license to practice in any state been (voluntarily or involuntarily) denied, limited, suspended, reprimanded, revoked, relinquished, or is your license to practice in any state under current challenge? ☐ Yes ☐ No
3. In the past two years have you been suspended, sanctioned, or otherwise restricted from participating in any private, federal or state health insurance program? (for example Medicare or Medicaid) ☐ Yes ☐ No
4. In the past two years have you been the subject of an investigation by any private, federal or state agency concerning your participation in any private, federal or state health insurance program? ☐ Yes ☐ No
5. In the past two years has your narcotics registration certificate and/or DEA been (voluntarily or involuntarily) limited, suspended, revoked, relinquished, or is it currently being challenged or reviewed? ☐ Yes ☐ No
6. In the past two years has your employment, staff appointment, clinical privileges and/or scope of practice ever been (voluntarily or involuntarily) suspended, limited, revoked, not renewed, or refused at any hospital or other healthcare facility? ☐ Yes ☐ No
7. In the past two years have you ever withdrawn your application for appointment, reappointment, clinical privileges and/or scope of practice, or resigned before a decision by a hospital's or healthcare facility's governing body was rendered? ☐ Yes ☐ No
8. In the past two years have you been the subject of disciplinary proceedings or investigation at any hospital or healthcare facility? ☐ Yes ☐ No
9. Is your staff appointment or clinical privileges and/or scope of practice at any hospital or other healthcare facility currently under investigation? ☐ Yes ☐ No
10. In the past two years have you been denied membership or renewal thereof, or been subject to disciplinary proceedings in any professional organization? ☐ Yes ☐ No
11. In the past two years have you entered into any agreement (voluntarily or involuntarily) with any licensing organization or accrediting board to limit your medical practice as a result of any condition, mental or physical, which you suffer, including but not limited to alcoholism or substance abuse? ☐ Yes ☐ No
12. In the past two years have you been charged or convicted of a felony or a misdemeanor other than a minor traffic violation? ☐ Yes ☐ No

Please answer each of the following questions in full. If the answer to any of the following is yes, please provide a full explanation of the details on a separate sheet and attach.

1. In the past two years has your professional liability insurance coverage been terminated by action of the insurance company? ☐ Yes ☐ No
2. In the past two years have you been denied professional liability insurance coverage? ☐ Yes ☐ No
3. In the past two years has any professional liability insurance carrier excluded any specific procedures from your coverage? ☐ Yes ☐ No
4. In the past two years have you practiced medicine without professional liability insurance? ☐ Yes ☐ No

If the answer to any of the following is yes, please complete Malpractice Claims Assessment Form (Form B)

5. In the past two years have any professional liability suits been filed against you or have you received written notice of intent to file such a suit? ☐ Yes ☐ No
6. In the past two years have any professional liability suits been filed against you, which are presently pending? ☐ Yes ☐ No
7. In the past two years have any judgments been made against you or settlements rendered on your behalf in any professional liability cases? ☐ Yes ☐ No

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1. If you are granted clinical privileges and/or scope of practice, do you agree to notify the Hospital of any change to the foregoing answers upon the occurrence of any event, which would or does render any of the foregoing answer(s) incorrect or incomplete? ☐ Yes ☐ No
2. Do you understand and acknowledge that it is an express condition to ongoing clinical privileges and/or scope of practice to notify the Hospital of any occurrence/event which renders the foregoing answers incorrect or incomplete when notice of the same is received by you? ☐ Yes ☐ No

E. HEALTH STATUS

Do you have any physical or mental conditions, which could affect your ability to exercise the clinical privileges requested or would require an accommodation in order for you to exercise the privileges requested safely and competently? To answer this question appropriately, please report any condition, which is infectious, which affects motor skills, cognitive ability or judgment, or which may adversely affect your ability to care for patients or to interact with other caregivers? ☐ Yes ☐ No

Do you know of any reason that would prevent you from performing all the essential functions required by the privileges you requested without posing a substantial risk of serious harm to yourself, your patients, or others? ☐ Yes ☐ No

F. CONTINUING MEDICAL EDUCATION

Please provide/attach documentation of a minimum of 10 Category I hours annually of CME/CEU directly related to the clinical privileges requested.

G. STAFF STATUS REQUESTED

KMC: ☐ Active* ☐ Associate/membership only ☐ Courtesy

☐ Associate/clinical privileges only

SMC: ☐ Active* ☐ Associate/membership only ☐ Courtesy

☐ Associate/clinical privileges only

**those applicants who receive Active staff appointment at KMC or SMC, per the Medical Staff Bylaws, will be automatically granted affiliate appointment without privileges at the other Hospital.*

H. APPLICANT'S STATEMENT

In applying for Medical Staff membership and/or clinical privileges at Kettering Medical Center (KMC) and/or Sycamore Medical Center (SMC), I hereby signify my willingness to appear for interviews in regard to my application. I acknowledge that I have received and read the Medical Staff Bylaws and associated Medical Staff manuals of the Hospital(s). I agree to be bound by the terms of said Bylaws and associated manuals as such Bylaws and manuals may from time to time be enacted/amended if I am granted membership or clinical privileges and/or scope of service and in all matters relating to the consideration of my application for appointment to the medical staff and clinical privileges.

I also acknowledge my obligation as a licensed health care professional to engage in my profession in a manner which is consistent with and in compliance with all applicable federal and state laws. This includes, but is not necessarily limited to, all federal and state laws addressing the obligation to comply with conditions of participation for government sponsored health care entitlement programs. Consistent therewith, I have read the information provided in the HIPAA Review for Practitioners and I agree to abide by the principles set forth in that document. I further expressly agree to abide by the policies and procedures of the hospital as applicable to my professional practice and will also abide by the requirements of the Hospitals' third party accreditation entities.

I agree to submit my clinical performance to, and faithfully participate in the Hospitals' performance improvement program(s) and I agree to hold the Hospitals, their Medical Staffs, and their directors, officers, members/employees, representatives and agents engaged in such quality activities free from all liability for their actions performed in connection therewith. I hereby consent for the Hospitals to notify the Montgomery County Medical Society, other hospitals, licensing boards, and other organizations concerned with provider performance and the quality and efficiency of patient care with any information relevant to such matters that the Hospitals may have concerning me and release the Hospitals, their Medical Staffs, and their directors, officers, members/employees, representatives and agents from liability for so doing. I further specifically acknowledge that the provisions the Medical Staff Bylaws and/or associated manuals relating to confidentiality and release from civil liability are express conditions to my application for, and acceptance/ continuation of Medical Staff membership and/or to the exercise of clinical privileges. I pledge to provide for continuous care for my patients and to fulfill such other responsibilities as may be required in the event I am granted Medical Staff membership and/or clinical privileges

I understand and agree that I, as an applicant for Medical Staff membership and/or clinical privileges, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications for membership and clinical privileges as well as resolving any doubts about such qualifications. I attest that the information that I have provided in correct and complete, and understand that any significant misstatements in or omissions from the CAQH Application or this addendum constitute cause for denial of appointment/privileges or cause for dismissal from the Medical Staff/termination of privileges. If appointment/privileges are granted, I understand that my initial Medical Staff appointment/privileges will be provisional for a period of one (1) year and, if necessary, may be extended another year. I understand and agree that if Medical Staff membership and/or requested privileges are denied or terminated based upon my quality of care or professional conduct/competence, I may be subject to reporting to the National Practitioner Data Bank and/or applicable State authorities. I further agree that in the event an adverse recommendation or action is made with respect to Medical Staff members and/or privileges, I will exhaust the administrative remedies afforded by the Medical Staff Bylaws, if applicable, before resorting to formal legal action. I agree to immediately notify the Hospitals if any information contained in my CAQH application or this addendum changes. I further agree that the foregoing obligation shall be a continuing obligation so long as I hold Medical Staff membership and/or privileges are the Hospital(s).

I have submitted a passport size photograph and give the right and my permission for Kettering Health Network ("KHN") and any of its affiliated hospitals, clinics and health centers with which I am associated to use and distribute this photograph and other professional biographical information for purposes of identification, world wide web publication, and other general public distributions in connection with educational, public relations, media relations, marketing, promotional, communications, and other charitable purposes.

ALL INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE BY MY BEST KNOWLEDGE AND BELIEF.

Signature of Applicant____ Date______________

KETTERING MEDICAL CENTER SYSTEM
KETTERING HEALTH NETWORK™

AUTHORIZATION FOR THE RELEASE OF INFORMATION AND LIABILITY

I hereby authorize and expressly consent for Kettering Medical Center (KMC), Sycamore Medical Center (SMC) hereinafter called "Hospital(s)", the members of Hospitals' Medical Staffs, and the Hospitals' employees, agents and representatives to consult with administrators and members of the medical staff and credentialing organizations, other hospitals, healthcare institutions, and healthcare providers with whom I have been associated and/or previously applied for medical staff appointment and/or privileges and with others, including past and present malpractice carriers, licensing agencies, peers, educational institutions, government programs, and credentialing reporting agencies which may have information bearing on my professional activities, competence, character, and/or ethical qualifications.

I acknowledge that the Medical Staffs of the Hospitals are comprised of licensed physicians, podiatrists, psychologists and dentists who practice their respective specialty in and around Dayton, Ohio and who have been granted medical staff appointment and/or clinical privileges at the Hospitals. The members of the Medical Staffs of the Hospitals are not, for purposes of credentialing and peer review processes and functions, employees of the Hospitals; but, rather, are licensed independent practitioners participating in Hospitals' credentialing and peer review processes.

I consent to the inspection by Hospitals, the members of its Medical Staffs, and its employees, agents, and representatives of all documents, including but not necessarily limited to peer review evaluation records, educational records, clinical competency evaluations, and credentialing files maintained by other hospitals or other healthcare institutions, that may be material to an evaluation of my personal and professional activities, professional qualifications and competence to perform and carry out the clinical privileges as requested, as well as my moral and ethical qualifications for medical staff membership and/or clinical privileges at Hospitals.

I hereby release from and agree to hold Hospital, the members of their Medical Staffs, and the directors, officers, employees, agents, and representatives thereof harmless from and for any liability for performed in connection with evaluating my credentials, qualifications, and application for medical staff membership and/or privileges. I further release from any liability, and hold harmless, any individuals or organizations who provide information to the Hospitals and the members of Hospitals' Medical Staffs, concerning my past personal and professional activities, professional competence, ethics, character, and other qualifications for appointment and/or granting of clinical privileges and/or scope of service.

I am willing to appear, if requested, for interviews in reference to my application or addendum..

I understand and acknowledge that Hospitals, the members of Hospitals' Medical Staffs, and employees, agents and representatives thereof may be required to report to licensing agencies, (e.g. the State Medical Board), the National Practitioner Data Bank, and other credentialing and accrediting agencies or government entities information regarding my appointment, clinical privileges and/or scope of service, disciplinary action (if any) and professional conduct/competence which may otherwise be protected from disclosure as confidential peer review information. I hereby release from and agree to hold Hospitals, the members of Hospitals' Medical Staffs, and employees, agents and representatives thereof harmless from and for any liability for the release of such information when Hospitals and/or its Medical Staffs, by and through their/members, employees, agents and/or representatives, disclose such information in compliance with such laws and regulations.

I further understand that, pursuant to written authorization by me or a duly entered court order, the Hospitals, Medical Staffs, And the employees, members, agents and representatives thereof may provide to other hospitals, organizations, insurers, healthcare providers, reporting and accrediting agencies and other persons information concerning my professional competence, character, ethics, credentials and credentialing status, clinical privileges and/or scope of service status, appointment and other peer review information. I hereby release from and agree to hold Hospitals, Hospitals' Medical Staffs and the members, employees, agents and representatives thereof harmless from and for any liability for release of such information, pursuant to my written authorization or a duly entered court order. I agree to sign such additional authorizations and release of information consent forms as may be necessary in conjunction with my application for medical staff membership or privileges at Hospital(s).

A copy of this sign and dated authorization shall have the same effect as the original.

______________________________________ ____________________
Applicant's Signature Date

____
Print Name

MALPRACTICE CLAIMS ASSESSMENT FORM

<table>
<tr><td colspan="3">Name:</td><td>Date</td></tr>
<tr><td colspan="3">Patient Name:</td><td>DOB:</td></tr>
<tr><td colspan="3">Civil Action #:</td><td>Date of Incident:</td></tr>
<tr><td>Date filed:</td><td>Date Settled/Closed:</td><td colspan="2">Professional Involvement:
Attending/Resident/Other</td></tr>
<tr><td colspan="4">Diagnosis:</td></tr>
<tr><td colspan="4">Allegations:</td></tr>
<tr><td colspan="4">Case Summary:</td></tr>
<tr><td colspan="4">CASE RESOLUTION</td></tr>
<tr><td>Dismissed:</td><td>Settled out-of-court:</td><td colspan="2">Litigated:</td></tr>
<tr><td colspan="4">Venue:</td></tr>
<tr><td colspan="2">Settlement paid on your behalf:</td><td colspan="2">Total Settlement:</td></tr>
<tr><td colspan="4">PROFESSIONAL LIABILITY INFORMATION</td></tr>
<tr><td colspan="3">Name of Insurance Carrier:</td><td>Policy Number:</td></tr>
<tr><td colspan="4">Address:</td></tr>
<tr><td colspan="4">PLAINTIFF’S COUNSEL</td></tr>
<tr><td colspan="3">Name of attorney</td><td>Phone Number:</td></tr>
<tr><td colspan="4">Address:</td></tr>
<tr><td colspan="4">OTHER APPLICABLE INFORMATION</td></tr>
<tr><td colspan="4"></td></tr>
</table>

PROFESSIONAL SANCTIONS REPORTING FORM

Name: ____________________ **Dept./Section**: ______________ **Date:** __________

Facility Name: ____

Contact Person: ____________________ Phone: ______________

Date incident occurred: ____________________ **Status (check one):** ☐ Pending ☐ Closed

Substance of allegations: ____

If closed, disposition (check one): ☐ Dismissed ☐ Disciplinary Action Taken

Substance of findings: ____

____

Additional Information (optional): ____

____

Name: ____________________ **Dept./Section**: ______________ **Date:** __________

Facility Name: ____

Contact Person: ____________________ Phone: ______________

Date incident occurred: ____________________ **Status (check one):** ☐ Pending ☐ Closed

Substance of allegations: ____

If closed, disposition (check one): ☐ Dismissed ☐ Disciplinary Action Taken

Substance of findings: ____

____

Additional Information (optional): ____

____

******SEND DIRECTLY TO YOUR PROFESSIONAL LIABILITY INSURANCE CARRIER******

(this includes both recent past and current carrier)

STATEMENT OF AUTHORIZATION AND RELEASE FROM LIABILITY

Name and Address of Professional Liability Insurance Carrier:

____

____

____

POLICY #: ________________________________

To Whom It May Concern:

I, ____, am applying for Medical Staff appointment, clinical privileges and/or scope of service at Kettering Medical Center/Sycamore Medical Center and hereby authorize my professional liability insurance carrier to release to the individual and facility listed below all information regarding my claims history, including, but not limited to:

- Judgments entered
- Claims settled
- Cases pending
- Procedures not covered by my policy

This information shall be submitted to:

Melissa Walters, MHA, CPMSM, CPCS
Central Credentialing Office
Kettering Medical Center
3535 Southern Blvd.
Kettering, OH 45429
937-395-8324 (phone)
937-395-8357 (FAX)

The above named person and Kettering Medical Center or Sycamore Medical Center, as appropriate, is to hereinafter be listed as a Certificate Holder and shall be notified of the amount of my coverage and any future changes in my insurance status.

Your prompt and full response will be appreciated. My signature below constitutes consent to this inquiry, authorizes your response thereto, and releases you from liability for reporting/providing the requested information as specified above.

Sincerely,

_____________________________________ _________________________________

Signature of Applicant/Insured Date

KETTERING MEDICAL CENTER SYSTEM

TB Evaluation for Medical Staff Members
& Allied Health Professionals

The following information on all individuals working or providing care to patients at Kettering Medical Center and/or Sycamore Medical Center must be obtained. Please complete the following questions and return to the Central Credentialing Office at 3535 Southern Blvd., Kettering, OH 45429 or via fax to 937-395-8357:

TB Skin Test	BAMT
Test Date: _________	Test Date: _________
Date Read: ________	Date Read: ________
☐ Positive ☐ Negative	☐ Positive ☐ Negative

If you are a positive TB skin test positive and if not BAMT negative, you must answer the following questions:

DO YOU NOTE ANY OF THE FOLLOWING?

YES	NO	
☐	☐	1. Persistent cough for longer than three weeks?
☐	☐	2. Chest Pain?
☐	☐	3. Shortness of breath
☐	☐	4. Presently coughing up phlegm, sputum or blood?
☐	☐	5. Noted fever, chills or night sweats?
☐	☐	6. Persistent tiredness, weakness or generally not feeling well?
☐	☐	7. Loss of appetite?
☐	☐	8. Noted weight loss not related to dieting or exercise?

☐ ☐ Chest x-ray Date: _______ ☐ Positive ☐ Negative

If you are a recent converter, contact your physician for advice on TB prophylaxis.

9. Have you had any health problems or infectious diseases in the last 12 months which would affect with the practice of your clinical privileges at Kettering Medical Center and/or Sycamore Medical Center?

☐ YES* ☐ NO

*If you answer yes, please provide a detailed description of the health problem.

____
Appointee Signature

______________________________ ________________________
Printed Name Date

800.999.9861
713.861.5959
info@precheck.com
www.PreCheck.com

KETTERING HEALTH NETWORK MED STAFF # 8637
PRACTITIONER DISCLOSURE & AUTHORIZATION

APPLICANT'S FULL NAME ______________________________

Any Other Names Used ______________________________

Social Security No. _______ /_____ / __________ Date of Birth[1] ______________________________

Current Address ______________________________

City ______________________ State ____________ Zip ______________________

Driver's License State ____________________ No. ______________________

Address: ______________________________

Have you ever been convicted of a crime? Yes ☐ No ☐

Offense ______________________County ______________ State ________ When________

Please provide all locations where you have resided or practiced for the past ten (10) years, starting with your current residency.

	City	State	Dates From:	To:
1.	______________ /	______________	______________	______________
2.	______________ /	______________	______________	______________
3.	______________ /	______________	______________	______________
4.	______________ /	______________	______________	______________
5.	______________ /	______________	______________	______________
6.	______________ /	______________	______________	______________
7.	______________ /	______________	______________	______________
8.	______________ /	______________	______________	______________

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

Kettering Health Network may obtain information about you from a consumer reporting agency made in connection with your application for employment, contract or privileges. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews. These reports may contain information regarding your criminal history, social security verification, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by PreCheck, Inc., 3453 Las Palomas Rd. Alamogordo, NM 88310; 1(888)PreCheck [1-888-773-2432] or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and throughout the course of your employment, contract, privileges or appointment to the extent permitted by law.

1 The Age Discrimination in Employment Act of 1987 prohibits discrimination on the basis of age with respect to individuals who are at least 40 years of age. This information is necessary for the proper processing of a consumer report.

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of “consumer reports” and/or “investigative consumer reports” by the Company at any time after receipt of this authorization and throughout the term of my employment, contract or privileges, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by PreCheck, Inc., 3453 Las Palomas Rd. Alamogordo, NM 88310; 1(888) PreCheck [1-888-773-2432] another outside organization acting on behalf of the Company, and/or the Company itself. I agree that a facsimile (“fax”), electronic or photographic copy of this Authorization shall be as valid as the original.

STATE LAW NOTICES

Minnesota or **Oklahoma** applicants or employees only: Please mark an X in the designated field if you would like to receive a free copy of a consumer report if one is obtained by the Company. The report will be mailed to the current address you indicated on this form. _____

California applicants or employees only: Please mark the following field if you would like to receive a copy of an investigative consumer report or consumer credit report at no charge if one is obtained by the Company whenever you have a right to receive such a copy under California law. The report will be mailed to the current address indicated above. _____

California applicants or employees only: By marking an X in the designated field, you will receive and are acknowledging receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. _____

New York applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by the Client by directly contacting PreCheck Inc. Additionally, please mark this field to receive and acknowledge receipt of a copy of Article 23-A of New York Correction Law. ____

Maine applicants or employees only: Under Chapter 210 Section 1314 of Maine Revised Statutes, you have the right, upon request, to be informed within 5 business days of such request of whether or not an investigative consumer report was requested. If such report was obtained, you may contact the Consumer Reporting Agency and request a copy.

Massachusetts applicants or employees only: If you ask, you have the right to a copy of any background check report concerning you that the Company has ordered. You may contact the Consumer Reporting Agency for a Copy.

Washington State applicants or employees only: You have the right, upon written request made within a reasonable period of time after your receipt of this disclosure, to receive from the Company a complete and accurate disclosure of the nature and scope of the investigation we requested. You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.

I have read and understand the above information and assert that all information provided by me is true and accurate.

Signature ____ **Date**