TOPPENISH COMMUNITY HOSPITAL
502 West 4th Avenue, Toppenish, WA 98948
Medical Staff Services: (509) 865-1520 Fax: (509) 865-1519

Pre-application For Allied Health Professional Membership

(This form must be legible and completed in full)

NAME IN FULL:	**DATE:**
Any Other Name Used in Professional Practice:	
Office Address:	**Office Phone:**
Local Office Practice/Physician Supervisor(s); (complete the attached agreement for each supervisor)	
Residence Address:	**Residence Phone:**
E-mail Address:	
Clinical Specialty:	
Professional School Name/Location:	**Grad. Date:**
Anticipated Start Date:	

Yes	No	Description
❍	❍	Copy of Washington State license attached? **PA.'s must also provide a copy of approved Utilization Plan**
❍	❍	If no, copy of licensure application attached?
❍	❍	Copy of DEA certificate, if applicable, attached?
❍	❍	Copy of current professional liability insurance in the amount approved by the Board attached? ($1/3)
❍	❍	Copy of current Curriculum Vitae attached?
❍	❍	Proof of meeting eligibility requirements for privileges in your category attached? This may include certificate from professional school and/or certification in your specialty
❍	❍	Proof of Board Certification status as required for privileges in the Department to which you are applying attached?
❍	❍	Signed Washington State Criminal Background form included?
❍	❍	Signed Child and Adult Abuse Information Disclosure form included?
❍	❍	Attached copy of practice plans and planned utilization of Toppenish Community Hospital.

Please attach any explanations to this form if needed in response to the above items

My degree is (check one): ___ARNP ___CRNA ___Physician Assistant

Having provided the information requested above , I request an application for appointment to the Allied Health Professional Staff

SIGNATURE:_____ **DATE:**_____

Application Format Requested: ❍ E-mail to above address ❍ Paper Copy (must be typed)

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PRE-APPLICATION ACKNOWLEDGEMENT

I acknowledge that by submitting this pre-application form, Toppenish Community Hospital will complete the following queries to determine my eligibility to receive an application to the Allied Health Professional Staff:

- National Practitioner Data Bank query
- Washington State Patrol criminal background query *
- Talentwise background check in all other states* (separate release)
- OIG / SAM query for Medicare/Medicaid sanctions
- Washington State licensure query (if current WA state license held)
- DEA Certificate query (if applicable)

When a Pre-application Applicant has been determined not to have met the basic pre-application requirements for Staff appointment, the practitioner will be so advised by letter. The determination that an applicant is not eligible for membership and/or privileges is an administrative determination and shall not entitle the applicant to any of the procedures under the *Fair Hearing Plan*.

Signed:_____ Date:_____

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PRACTICE PLANS AND PLANNED UTILIZATION OF TOPPENISH COMMUNITY HOSPITAL:

___**Solo Practice** __**Yes** __**No** I have made plans for on-call coverage with other physicians

___**Group Practice, name:**_____

Anticipated start date:_____

Describe your planned utilization of Toppenish Community Hospital:

_____

_____

_____

_____

_____

_____

Based on the attached "Board Certification Requirements by Specialty," I request the following specialty privilege form/s be provided:

Patient Care Categories:

☐ Anesthesia ☐ Emergency Medicine

Signed:_____ Date:_____

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+WASHINGTON PRACTITIONER ATTESTATION QUESTIONS - ***To be completed by the practitioner***

Please answer all of the following questions. If your answer to any of the following questions is 'Yes", provide details as specified on a separate sheet. *If you attach additional sheets, sign and date each sheet.*

A.	**PROFESSIONAL SANCTIONS**			
1.	Have you ever been, or are you now in the process of being denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily or involuntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct?			
	a.	License to practice any profession in any jurisdiction	YES ☐	NO☐
	b.	Other professional registration or certification in any jurisdiction	YES ☐	NO☐
	c.	Specialty or subspecialty board certification	YES ☐	NO☐
	d.	Membership on any hospital medical staff	YES ☐	NO☐
	e.	Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.	YES ☐	NO☐
	f.	Medicare, Medicaid, FDA, NIH (Office of Human Research Protection), governmental, national or international regulatory agency or any public program	YES ☐	NO☐
	g.	Professional society membership or fellowship	YES ☐	NO☐
	h.	Participation/membership in an HMO, PPO, IPA, PHO or other entity	YES ☐	NO☐
	i.	Academic Appointment	YES ☐	NO☐
	j.	Authority to prescribe controlled substances (DEA or other authority)	YES ☐	NO☐
2.	Have you ever been subject to review, challenges, and/or disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, professional association or education/training institution?		YES ☐	NO☐
3.	Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?		YES ☐	NO☐
4.	Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?		YES ☐	NO☐
B.	**CRIMINAL HISTORY**			
1.	Have you ever been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation?		YES ☐	NO☐
	a.	Do you have notice of any such anticipated charges?	YES ☐	NO☐
	b.	Are you currently under governmental investigation?	YES ☐	NO☐
C.	**AFFIRMATION OF ABILITIES**			
1.	Do you presently use any drugs illegally?		YES ☐	NO☐
2.	Do you have, or have you had in the last five years, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or will affect your current ability to practice with or without reasonable accommodation? If reasonable accommodation is required, specify the accommodations required. If the answer to this question is yes, please identify and describe any rehabilitation program in which you are or were enrolled which assures your ability to adhere to prevailing standards of professional performance.		YES ☐	NO☐
3.	Are you unable to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital agreement, with or without reasonable accommodation, according to accepted standards of professional performance?		YES ☐	NO☐
D.	**LITIGATION AND MALPRACTICE COVERAGE HISTORY (If you answer "Yes" to any of the questions in this section,** please document in Section XXI. PROFESSIONAL LIABILITY ACTION DETAIL of this application.)			
1.	Have allegations or claims of professional negligence been made against you at any time, whether or not you were individually named in the claim or lawsuit?		YES ☐	NO☐
2.	Have you or your insurance carrier(s) ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgment (court-ordered damage award) in a professional lawsuit?		YES ☐	NO☐
3.	Are there any such claims being asserted against you now?		YES ☐	NO☐
4.	Have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged)?		YES ☐	NO☐
5.	Are any of the privileges that you are requesting not covered by your current malpractice coverage?		YES ☐	NO☐

I warrant that all the statements made on this form and on any attached information sheets are complete, accurate, and current. I understand that any material misstatements in, or omissions from, this statement constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been submitted.

Applicant's Signature:_____ Date:_____

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XXI. PROFESSIONAL LIABILITY ACTION DETAIL – CONFIDENTIAL	**Does Not Apply** ☐
Practitioner Name:(print or type)	
Please list any past or current professional liability claim(s) or lawsuit(s), in which allegations of professional negligence were made against you, whether or not you were individually named in the claim or lawsuit. Please do not include patient names or other HIPAA protected PHI. Photocopy this page as needed and submit a separate page for EACH claim/event. A legible signed practitioner narrative that addresses all of the following details is an acceptable alternative.	
Date and clinical details of the incident, with preceding events: Date: Details:	
Your role and specific responsibility in the incident:	
Subsequent events, including patient's clinical outcome:	
Date suit or claim was filed:	
Name and Address of Insurance Carrier that handled the claim:	
Your status in the legal action (primary defendant, co-defendant, other):	
Current status of suit or other action:	
Date of settlement, judgment, or dismissal:	
If case was settled out-of-court, or with a judgment, settlement amount attributed to you? **$**	

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WASHINGTON STATE PATROL

Identification and Criminal History Section
PO Box 42633
Olympia WA 98504-2633
(360) 705-5100
https://watch.wsp.wa.gov

REQUEST FOR CONVICTION CRIMINAL HISTORY RECORD (RCW 10.97)

INSTRUCTIONS: PLEASE COMPLETE THIS FORM WHEN REQUESTING **CONVICTION** CRIMINAL HISTORY RECORD INFORMATION FROM THE IDENTIFICATION AND CRIMINAL HISTORY SECTION. MAIL REQUEST TO ADDRESS NOTED ABOVE WITH $35.00 CHECK OR MONEY ORDER OR COME TO OUR OFFICE AT 3000 PACIFIC AVENUE, OLYMPIA, WA. ***NOTE: IT MAY TAKE 7 TO 14 BUSINESS DAYS FOR RESPONSE WHEN MAILED. FOR AN IMMEDIATE RESPONSE, ACCESS OUR WEB SITE LISTED ABOVE TO CONDUCT YOUR CRIMINAL HISTORY REQUEST FOR $10.00 USING A CREDIT CARD.***

NOTARIZED LETTERS ARE AN ADDITIONAL $5.00 PER NOTARY SEAL _____**Notarized Letter(s)**

NOTE: The requested record information is furnished solely on the basis of name and/or description similarity with the subject of your inquiry. Positive identification or non-identification can only be effected upon receipt of fingerprints. Applicant may be advised of inquiry.

A **SUBJECT INFORMATION:** **(Please type or print clearly)**

Applicant's Name: _____
Last First Middle

Alias/Maiden Name: _____

Date of Birth: _____ Sex: _____ Race: _____
Month/Day/Year

Social Security Number: _____ Drivers Lic. Number/State _____/____

WSP USE ONLY

B **REQUESTER INFORMATION:** (P[illegible]r print clearly)

DATE: ___/___/___ _____
Mo. Day Yr. (print) Name) quester

PHONE No. (____) _____
ester's Signature

REQUESTER'S ADDRE[illegible]ype or clearly s[illegible]ress)

_____ Right Thumb Print (Optional)
Requesting Agency

Name

Address

City State

3000-240-569 (R 7/05)

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CHILD AND ADULT ABUSE INFORMATION DISCLOSURE FORM

The job for which you have applied may require unsupervised access to children under 16 years of age, to vulnerable adults or to developmentally disabled persons. The Hospital will request from the Washington State Patrol information relative to any convictions you may have had of offenses against persons, adjudications of child abuse or disciplinary board final decisions.

"Crime against children or other persons" means a conviction of any of the following offenses: aggravated murder; first or second degree murder; first or second degree kidnapping; first, second, or third degree assault; first, second, or third degree assault of a child; first, second, or third degree rape; first, second, or third degree rape of a child; first or second degree robbery; first degree arson; first degree burglary; first or second degree manslaughter; first or second degree extortion; indecent liberties; incest; vehicular homicide; first degree promoting prostitution; communication with a minor; unlawful imprisonment; simple assault; sexual exploitation of minors; first or second degree criminal mistreatment; child abuse or neglect as defined in RCW 26.44.020; first or second degree custodial interference; first or second degree custodial sexual misconduct; malicious harassment; first, second, or third degree child molestation; first or second degree sexual misconduct with a minor; patronizing a juvenile prostitute; child abandonment; promoting pornography; selling or distributing erotic material to a minor; custodial assault; violation of child abuse restraining order; child buying or selling; prostitution; felony indecent exposure; criminal abandonment; or any of these crimes as they may be renamed in the future.

"Crime relating to financial exploitation" means a conviction of any of the following offenses, if the victim was a vulnerable adult: first, second, or third degree extortion; first, second, or third degree theft; first or second degree robbery; forgery; or any of these crimes as they may be renamed in the future.

"Crime relating to drugs" means a conviction of a crime to manufacture, delivery, or possession with intent to manufacture or deliver a controlled substance.

We are also required to ask you the following questions:

1. Have you ever been convicted of any of the above-defined crimes? If so, which: _____
   _____
2. Have you ever been found, under RCW 13.34.020(2)(b), to have sexually assaulted, exploited or physically abused any minor? _____
3. Have you ever been found by a court, in a domestic relations proceeding, under Title 26 RCW, to have sexually abused, exploited or physically abused a minor? _____
4. Have you ever been found, in any disciplinary board final decision, to have sexually abused, exploited or physically abused a minor? _____

* *

I SWEAR, UNDER THE PENALTY OF PERJURY, THAT THE ANSWERS GIVEN ON THIS DISCLOSURE FORM HAVE BEEN MADE BY ME AND ARE TRUE AND CORRECT.

_____ _____
Signature Print Name

_____ _____
Date Date of Birth

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ALLIED HEALTH PROFESSIONAL ELIGIBILITY REQUIREMENTS

Please check the appropriate category

	☐ **Anesthesia CRNA**	☐ **Emergency Department ARNP**
Advanced Registered Nurse Practitioners	Licensed in Washington as an ARNP ***Complete Anesthesia Program recognized by the AANA*** Certified as a CRNA by the AANA. (If the applicant has just graduated from a CRNA Program, he/she must be Board Qualified for CRNA status and successfully complete the first available AANA exam.	Licensed in Washington as an ARNP Certified as an ARNP by the ANCC or AANP.
Physician Assistants	Licensed in Washington by the Medical Quality Assurance Commission as P.A. or the applicable state licensing board for Osteopathy. Signed & Approved Utilization Plan in place.	

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APPLICANT'S STATEMENT AND RELEASE FROM LIABILITY

By submitting this authorization and release of information form in conjunction with the Washington Practitioner Application (WPA) and/or the Washington Practitioner Attestation, I understand and agree as follows:

Agreement to abide by Bylaws, Rules & Policies: I am applying to the Governing Body of Toppenish Community Hospital for appointment to the Professional Staff and/or for clinical privileges to treat patients therein, and understand the By-Laws and Rules and Regulations of the Medical Staff and I agree to abide by the applicable Staff By-Laws and by such applicable rules and regulations as may from time to time be enacted by the Medical Staff and Governing Body of the applicable hospital(s).

Accuracy of Application and Adverse Rulings: Moreover, I specifically pledge that I will not receive from or pay to another Practitioner, either directly or indirectly, any part of a fee received for professional services, and I fully understand that any significant misstatements in, or omissions from, this application constitutes cause for summary dismissal from this Staff. I agree that when an adverse ruling is made with respect to Staff membership, Staff status, and/or clinical privileges, I will exhaust the administrative remedies afforded by these By-Laws before resorting to formal legal action. I state that I understand the appointment mechanism as described in the Policy "Appointment to the Medical Staff". I state that all information contained on this application form and supporting documents is accurate and complete to the best of my knowledge. I understand and agree that I, as an applicant for Staff Membership, have the burden of producing accurate and complete information for proper evaluation of my professional competence, character, ethics and other qualifications and of resolving any doubts about such information.

Statement of Qualification for Privileges: I believe that I am qualified to perform all procedures for which I have requested privileges. I have not requested privileges for any procedures for which I am not qualified, and I attest that I will not be performing procedures that are not within the scope of my insurance coverage. Furthermore, I realize that certification by a Board does not necessarily qualify me to perform certain procedures.

Release to Other Persons and Facilities: This is to authorize all current and past Hospital affiliations, their agents, employees, representatives and Medical Staff (collectively referred to as “Hospital” herein) to provide Toppenish Community Hospital and its agents, employees and representatives (collectively referred to as “TCH” herein) with any and all information and documentation that TCH may request regarding my professional qualifications, credentials, clinical competence, professional conduct, character, ethics and/or behavior, and any other matters that, in the Hospital’s sole judgment, might directly or indirectly affect my competence, patient care, or the orderly operation of Hospital or any other Healthcare facility. This authorization specifically includes, but is not limited to, any and all information and documentation related to peer review, quality review, or credentialing activities (including any disciplinary action or information relative to revocation, reduction, denial or suspension, or the contemplated revocation, reduction, denial or suspension of clinical privileges or membership) involving or pertaining to me during my tenure on the Medical Staff at any Hospital or by medical societies, state licensing bodies, the Federation of State Medical Boards, or any other authoritative body. Such information may also include review by appropriate Medical Staff or hospital representatives, either in person or by photocopied documents of medical records, of my clinical privileges at institutions where I hold or have held membership and/or clinical privileges for the purposes of evaluating my performance at these institutions. I understand that the confidentiality of all patients will be maintained

Absolute Immunity: I hereby extend **absolute immunity** to my current and past Hospital affiliations and any other institution, person, or group of persons, and release these entities/individuals from any and all liability, and agree not to sue these Hospitals, entities, or individuals for (1) providing the above information and documentation to Toppenish Community Hospital and (2) any action that may result from the provision of that information and documentation to Toppenish Community Hospital

Release to Insurers: I hereby authorize all past and present insurance carriers to release to Toppenish Community Hospital information concerning my professional liability/malpractice insurance coverage, including dollar limits of coverage, term of policy, and any claims that have been made against me.

Release of Information by Toppenish Community Hospital to outside interests: I hereby further authorize and consent to the release of information by Toppenish Community Hospital, or their respective Medical Staff, to other hospitals, medical associations, and other interested persons on request regarding any information the Hospital and the Medical Staff may have concerning me as long as such release of information is done in good faith and without malice, and I hereby release from liability Toppenish Community Hospital and its Medical Staff for so doing.

Joint Venture Disclosure: Each Physician who is a member of the Hospital’s Medical Staff agrees, as a condition of continued Medical Staff membership or admitting privileges, to disclose, in writing, to all patients the Physician refers to the Hospital, any ownership or investment interest in the Hospital that is held by the Physician or by an immediate family member of the Physician. Disclosure must be required at the time the referral is made.

Signature of Applicant; _____ **Date:** _____

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MEDICAL STAFF CONFLICT OF INTEREST DISCLOSURE FORM

Medical Staff Name: _____
Date: _____

The purpose of this form is to allow all Medical Staff leaders to disclose any actual or potential conflict of interest, as required by Joint Commission Leadership Standard LD.04.02.01 and as outlined in the Medical Staff Bylaws or applicable medical staff policy. When a relationship or potential relationship may present a conflict, such should be disclosed at the earliest possible date.

A. Please discuss all business or financial relationships or interests with (i) the Hospital or any affiliate; (ii) any entity in competition with the Hospital, or (iii) any third party entity which currently provides good and services to, or may seek to provide goods or services to the Hospital or any related or affiliated entity of the Hospital. (The CMS Open Payments database will be queried to obtain information about financial relationships with health care manufacturing companies and to confirm accuracy of the response to this inquiry.)

_____

_____

B. Please list any leadership position on another Medical Staff or educational institution that creates a fiduciary obligation on your behalf, including, but not limited to membership on the governing body, executive committee or service or department chairmanship with an entity or facility that competes directly or indirectly with the Hospital.

_____

_____

C. Please describe all relationships not disclosed above which might in any way bear on your opinions or decisions as a medical staff member or, as applicable, medical staff leader.

_____

_____

I hereby certify the foregoing information is true, correct and complete to the best of my knowledge and belief. I further certify that should I become aware of any other potential conflict of interest from the time of this disclosure until my next regular periodic disclosure; I will disclose such potential conflict within thirty days of becoming aware of same.

Signature: _____ Date: _____

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DISCLOSURE FOR BACKGROUND CHECK

Toppenish Community Hospital (the "Company") will procure a consumer report and/or investigative consumer report on you in connection with your application for employment purposes (including employment, volunteer, or independent contractor assignments, as applicable) as defined under the Fair Credit Reporting Act. These background reports may be obtained at any time after receipt of your authorization and, if you are hired or engaged by the Company, throughout your employment or contract period.

TalentWise Solutions LLC ("TalentWise"), a consumer reporting agency, will obtain the report for the Company. Further information regarding TalentWise, including its privacy policy, may be found online at www.TalentWise.com. TalentWise is located at 19910 North Creek Parkway, Suite 200, Bothell, WA 98011, and can be reached at (866) 338-6739.

The report may contain information bearing on your character, general reputation, personal characteristics, mode of living and/or credit standing. The information that may be included in your report include: *Social security number trace, criminal records checks, public court records checks, driving records checks, educational records checks, verification of employment positions held, personal and professional references checks, and licensing and certification checks*. The information contained in the report will be obtained from private and/or public record sources, including sources identified by you in your job application or through interviews or correspondence with your past or present coworkers, neighbors, friends, associates, current or former employers, educational institutions or other acquaintances. 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.

ADDITIONAL STATE LAW NOTICES

WASHINGTON: If the Company requests an investigative consumer report, 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 requested by the Company. 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.

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AUTHORIZATION

I have carefully read and understand this disclosure and authorization form and I have received a copy of the "Summary of Your Rights Under the Fair Credit Reporting Act" provided with this form. I have had the opportunity to review my rights. By my signature below, I consent to the preparation of background reports by TalentWise, and to the release of such reports to the Company and its designated representatives for the purpose of assisting the Company in making a determination as to my eligibility for employment, promotion, retention, contract assignment or for other lawful purposes.

I understand that, to the extent allowed by law, information contained in my job application or otherwise disclosed to the Company by me before or during my employment or contract assignment, if any, may be utilized for the purpose of obtaining such consumer reports and/or investigative consumer reports about me. I understand that nothing herein shall be construed as an offer of employment or contract for services.

I hereby authorize law enforcement agencies, learning institutions (including public and private schools and universities), information service bureaus, credit bureaus, record/data repositories, courts (federal/state/local), motor vehicle record agencies, my past or present employers, the military, and other individuals or sources to furnish any and all information on me that is requested by the consumer reporting agency.

By my signature (including electronic) below, I certify the information provided on and in connection with this form is true, accurate, and complete. I agree that this form in original, faxed, photocopied or electronic form will be valid for any background reports that may be requested by or on behalf of the Company.

By my signature (including electronic) below, I certify the information provided on and in connection with this form is true, accurate, and complete. I agree that this form in original, faxed, photocopied or electronic form will be valid for any background reports that may be requested by or on behalf of the Company.

First Name: _____

Full Middle Name: _____

Last Name: _____

Date of Birth: _____

SSN: _____

Address: _____
Street Address

_____
City, State, Zip

Drivers' License Number: _____ **State:** _____

Signature: _____ **Date:** _____

Email Address: _____ **Phone:** _____

☐ **CALIFORNIA**, **MASSACHUSETTS, MINNESOTA, NEW JERSEY, and OKLAHOMA** applicants or residents: You have a right to request a free copy of your report. Please check here if you would like Toppenish Community Hospital to provide you with a copy of your report.

*This information is being collected to conduct portions of the pre-application, to include the background check and NPDB.

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*For providers with a WA state drivers license only

Account Number

Attachment F
RELEASE OF INTEREST

Employer/Transit authority/Volunteer organization

Softech International Inc. is an agent or acting as agent on behalf of a
Contractor name
Subscriber for employment purposes or is an employee, prospective employee, or volunteer organization.

This is an authorization of:

1. Employee for release of abstract of driving records for employment purposes, at my employer's discretion for the full term of my employment; or
2. Prospective employee for release of abstract of driving record for employment purposes, not to exceed thirty (30) days from date signed; or
3. Volunteer for the release of abstract record for which the volunteer has submitted an application for a position that would require driving by the volunteer at the direction of the volunteer organization.

I, _____, am an employee, prospective employee, or volunteer of the
Employee/Prospective Employee/Volunteer Name
company named above and I request a copy of my official Driving Record in the state of Washington be released to my employer, prospective employer, or volunteer organization or their agent.

PRINT OR TYPE Employee/Prospective employee/Volunteer Full Name (First, Middle, Last)	WA driver license number or date of birth
Employee/prospective employee/Volunteer signature X	Date Signed

The Subscriber listed below agrees to, and shall indemnify and hold harmless the state of Washington, Department of License (DOL), the Director of DOL, and all DOL employees from any and all suits at law or equity, and from any and all claims, demands or loss of any nature, including but not limited to all costs and attorney's fees, arising from any incorrect or improper disclosure of individual names or addresses under this "Certification of Use;" any defects in any of Subscriber's procedures followed or omitted or arising from the failure of Subscriber or its officers, employees, customers, contractors or agents to fulfill any of its obligations under this Contract; or arising in any manner from any negligent act or omission by Subscriber or its officers, employees, customers, contractors or agents.

I hereby certify:

1. The company named below is an employer, prospective employer, or volunteer organization of the above-named individual.
2. That the information contained in the abstracts of driver records obtained from DOL shall be used in accordance with the requirements and in no way violate the provisions of RCW 46.52.130. No information contained therein will be divulged, sold, assigned, or otherwise transferred to any third person or party. The abstracts of driver records shall be used exclusively for:

I affirm that I am a representative authorized to bind the Subscriber named below.

Contractor/Subscriber name Toppenish Community Hospital	
Address 502 West Fourth Ave., Toppenish, WA 98948	
Authorized representative name Rita Murphy	Title Medical Staff Coordinator

_____ X _____
Date and Place Signed — Authorized representative signature

NOTE: The employer or prospective employer must maintain this record for a period of not less than two (2) years from the date of the most recent request. Failure to obtain all signatures or misuse of records obtained from the State of Washington may result in prosecution under RCW 46.52.130.

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A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT

Para información en español, visite www.consumerfinance.gov/learnmore o escribe a la Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to www.consumerfinance.gov/learnmore or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.**

• **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.

• **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:

- a person has taken adverse action against you because of information in your credit report;
- you are the victim of identity theft and place a fraud alert in your file;
- your file contains inaccurate information as a result of fraud;
- you are on public assistance;
- you are unemployed but expect to apply for employment within 60 days.

In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.consumerfinance.gov/learnmore for additional information.

• **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.

• **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.consumerfinance.gov/learnmore for an explanation of dispute procedures.

• **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.

• **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.

• **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need – usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.

• **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer.

Written consent generally is not required in the trucking industry. For more information, go to www.consumerfinance.gov/learnmore.

• **You may limit "prescreened" offers of credit and insurance you get based on information in your credit report.** Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-567-8688.

• **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.

• **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.consumerfinance.gov/learnmore.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. For information about your federal rights, contact:

TYPE OF BUSINESS:	CONTACT:
1.a. Banks, savings associations, and credit unions with total assets of over $10 billion and their affiliates.	a. Consumer Financial Protection Bureau 1700 G Street NW Washington, DC 20552
b. Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to the CFPB:	b. Federal Trade Commission: Consumer Response Center – FCRA Washington, DC 20580 (877) 382-4357
2. To the extent not included in item 1 above:	
a. National banks, federal savings associations, and federal branches and federal agencies of foreign banks	a. Office of the Comptroller of the Currency Customer Assistance Group 1301 McKinney Street, Suite 3450 Houston, TX 77010-9050
b. State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies, and Insured State Branches of Foreign Banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act	b. Federal Reserve Consumer Help Center P.O. Box 1200 Minneapolis, MN 55480
c. Nonmember Insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations	c. FDIC Consumer Response Center 1100 Walnut Street, Box #11 Kansas City, MO 64106
d. Federal Credit Unions	d. National Credit Union Administration Office of Consumer Protection (OCP) Division of Consumer Compliance and Outreach (DCCO) 1775 Duke Street Alexandria, VA 22314
3. Air carriers	Asst. General Counsel for Aviation Enforcement & Proceedings Aviation Consumer Protection Division Department of Transportation 1200 New Jersey Avenue, SE Washington, DC 20590
4. Creditors Subject to Surface Transportation Board	Office of Proceedings, Surface Transportation Board Department of Transportation

	395 E Street S.W. Washington, DC 20423
5. Creditors Subject to Packers and Stockyards Act, 1921	Nearest Packers and Stockyards Administration area supervisor
6. Small Business Investment Companies	Associate Deputy Administrator for Capital Access United States Small Business Administration 409 Third Street, SW, 8th Floor Washington, DC 20416
7. Brokers and Dealers	Securities and Exchange Commission 100 F St NE Washington, DC 20549
8. Federal Land Banks, Federal Land Bank Associations, Federal Intermediate Credit Banks, and Production Credit Associations	Farm Credit Administration 1501 Farm Credit Drive McLean, VA 22102-5090
9. Retailers, Finance Companies, and All Other Creditors Not Listed Above	FTC Regional Office for region in which the creditor operates or Federal Trade Commission: Consumer Response Center – FCRA Washington, DC 20580 (877) 382-4357