Summary Statement

I certify that the information in this document and any attached documents is true and correct. I agree that UCI School of Medicine (SOM), its representatives, and any individuals or entities providing information to UCI SOM in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this document, which is part of the UCI SOM Volunteer Physician application. In order for UCI to evaluate my application for participation in and/or my continued participation in this institution, I hereby give permission to release to this institution information about my medical malpractice insurance coverage and malpractice claims history. This authorization is expressly contingent upon my understanding that the information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless and until it is revoked by me in writing. I authorize my attorneys to discuss any information regarding this case with UCI SOM.

Print Name Here: _____

Physician Signature: _____ Date: _____

(Stamped Signature Is Not Acceptable)