MEMBERSHIP APPLICATION FEE

_____

Name (please print legibly)

_____

Address (primary office)

_____

Telephone (primary office)

_____ _____

Specialty CAQH Provider ID Number

Category of Medical Staff Membership at:

_____	_____	_____
McLaren Oakland	McLaren Macomb	McLaren Flint
_____	_____	_____
McLaren Greater Lansing	McLaren Bay Region	McLaren Central
_____	_____	_____
McLaren Northern	McLaren Lapeer Region	Other

I hereby acknowledge receipt of the Bylaws (the "Bylaws") of the McLaren Physician Hospital Organization ("the Corporation") and request consideration for membership in the Corporation in accordance with the Bylaws. If approved by the Trustees as a Member, I hereby agree to the following terms and conditions applicable to all Members:

1. I have enclosed $1,000 as my membership fee.
2. I hereby authorize the Board of Trustees to seek information regarding my practice which would be relevant in making decisions including, but not limited to, my malpractice history. I hereby release from liability and waive any claim that I otherwise may have against the Corporation or any party in possession of any information regarding my practice for its release of such information to the Board of Trustees.
3. I will fulfill all of the responsibilities and enjoy all the rights of membership unless and until terminated in accordance with the Bylaws.
4. I understand that the Board of Trustees of the Corporation will evaluate applications for membership based on the criteria stated in the Corporation's bylaws.
5. I understand and attest that my office meets performance standards set forth by NCQA in the following categories: physical accessibility, physical appearance and cleanliness, adequacy of waiting and exam room space, adequacy of medical/treatment record keeping, following the Institute of medicine's key core capabilities. I understand that I am subject to random audits of this information and must address any areas of deficiency within 60 calendar days of notification by MPHO quality performance analysts.

_____ _____

Signature of Applicant Date