APPLICATION FOR SPONSORSHIP OF RESEARCH ALLIED HEALTH PROFESSIONAL (Non-QMC Research Administrator or Research Support Personnel)

1. **IDENTIFYING INFORMATION OF THE SPONSOR**
(For completion by the sponsor) **Sponsor must be a physician with Queens privileges.**

1.1 Sponsor's Name in Full:

____
(Last) (First) (Middle) (Jr., Sr., III, M.D., etc.)

1.2 Social Security Number: ______________________

1.3 Office Address: ______________________________________
(Number) (Street) (Suite #)

____
(City) (State) (Zip Code)

Office Telephone: ____________ Answering Service Telephone: ____________

1.4 Residence Address: ______________________________________
(Number) (Street) (Suite #)

____
(City) (State) (Zip Code)

Residence Telephone: ______________________

1.5 Service/Department: ______________________

1.6 Position Title at The Queen's Medical Center: ______________________

1.7 E-mail address: ______________________

2. **PROPOSED SERVICES TO BE RENDERED BY THE RESEARCH ALLIED HEALTH PROFESSIONAL**

(For completion by the sponsor)

I hereby apply for use of the services of ______________________________, title ______________________________ for only my patients and or accessing information according to the following approved research protocols at The Queen's Medical Center. (Attach additional sheets as necessary). Under my direction and supervision, such proposed services to be performed are indicated on the attached job responsibilities list.

Research Protocol Title: ______________________________________
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Research RA# ______________________________________
(provided by: The Research and Institutional Review Committee, QMC)

SPONSORING PRACTITIONER'S CONSENT AND RELEASE

I FULLY UNDERSTAND that any significant mis-statements in or omissions from the application to The Queen's Medical Center submitted for proposed sponsored services to be rendered shall constitute cause for denial of approval. All information submitted within the application is true to my best knowledge and belief.

I HEREBY CERTIFY that I have observed or am familiar with the qualifications of the Research Allied Health Professional (RAHP) named in the application in the performance of the proposed sponsored services to be rendered and can therefore attest to his/her clinical competence in providing these services.

I UNDERSTAND AND AGREE that I, as the applicant for proposed sponsored services to be rendered, have the burden of producing adequate information for proper evaluation of my RAHP's qualifications, clinical competence, moral character and ethical qualifications and for resolving any doubts thereto.

I WILL ASSUME all medical-legal responsibility and liability for any and all acts or omissions of and services performed by my RAHP for my patients only and will indemnify, defend and hold harmless The Queen's Medical Center, its employees and agents from any and all liability incurred as a result of reliance upon any and all acts or omissions taken from services performed by my RAHP for my patients only.

I HEREBY SIGNIFY my willingness to appear for interviews with regard to the proposed sponsored services to be rendered by my RAHP and authorize representatives of The Queen's Medical Center and/or its Medical Staff to consult with representatives of other hospitals and/or their Medical Staffs, institutions, government agencies including licensing agencies professional liability insurance companies, professional associations, accreditation agencies and others who may have information bearing on my RAHP's professional qualifications, clinical competence, moral character, ethical qualifications and physical and mental condition. I hereby further consent to the inspection by representatives of The Queen's Medical Center and/or its Medical Staff of all records at other hospitals, institutions, government agencies including licensing agencies, professional liability insurance companies, professional associations, accreditation agencies and others that may be material to an evaluation of my RAHP's professional qualifications, clinical competence, moral character, ethical qualifications and physical and mental condition for the proposed sponsored services to be rendered and continuance or renewal thereof. I hereby release from liability all representatives of The Queen's Medical Center and/or its Medical Staff for their acts performed in good faith and without malice in connection with evaluating this application, my RAHP's credentials and qualifications.

I HEREBY RELEASE from any liability any and all individuals, hospitals, institutions, government agencies including licensing agencies, professional liability insurance companies, professional associations, accreditation agencies, and others who provide information to representatives of The Queen's Medical Center and/or its Medical Staff in good faith and without malice, concerning my RAHP's professional qualifications, clinical competence, physical and mental condition, moral character, and ethical qualifications for the proposed sponsored services to be rendered at The Queen's Medical Center (unless such information is false and the person providing it knew the information was false) and I hereby consent to the release of such information for the proposed sponsored services to be rendered at The Queen's Medical Center.

I HEREBY AUTHORIZE AND CONSENT to the release of information by representatives of The Queen's Medical Center and/or its Medical Staff, to other hospitals and/or their Medical Staffs, institutions, government agencies including licensing agencies, professional liability insurance companies, professional associations, accreditation agencies and other, upon request, regarding any information The Queen's Medical Center and/or its Medical Staff may have concerning my RAHP, as long as such release of information is done in good faith and without malice. I hereby release from liability all representatives of The Queen's Medical Center and/or its Medical Staff for so doing.

I HEREBY AUTHORIZE any company, organization, institution and financial institution with whom I have held, currently hold, or will hold malpractice financial responsibility to release, at any time requested by The Queen's Medical Center, any and all information relating to my RAHP's malpractice liability coverage and claims information.

I hereby authorize and direct any company, organization, institution or financial institution with whom I currently hold or may in the future hold malpractice financial responsibility to inform The Queen's Medical Center (c/o Human Resources) of any cancellation or amendment, in part or whole, of my RAHP's malpractice financial responsibility, together with detailed information as to alternative approved malpractice financial responsibility coverage to be obtained or changes planned, whichever is applicable.

I UNDERSTAND AND AGREE that until such time as I have received written notification from The Queen's Medical Center that the sponsorship of the RAHP has been approved, he/she will not begin to effect services at The Queen's Medical Center.

I ACKNOWLEDGE that a copy of this consent and release form shall be as binding as the original.

____ ________________
Signature of Sponsor Date

Typed or Print Name of Sponsor: ____

I HEREBY ACKNOWLEDGE THE INFORMATION PROVIDED ABOVE BY MY SPONSORING PRACTITIONER:

____ ________________
Signature of Research Allied Health Professional Date

Typed or Print Name of Research Allied Health Professional: ____