U. S. DEPARTMENT OF HOMELAND SECURITY U.S. COAST GUARD CG-6040 (Rev. 05-10)	ATTESTATION

Name *(Last, First, MI printed)*	
SSN	DOB

I affirm and attest that all information submitted by me in this application is correct and complete to the best of my knowledge and belief. I acknowledge that any material misstatements in or omissions from this application may constitute cause for denial of my application for staff membership or participation.

I have the responsibility to comply with USCG policies and procedures for Medical and Dental Staff, and to abide by USCG Standards of Conduct. I will keep my file current by informing Commandant (CG-1122), of any changes, including but not limited to: my demographic information, my state license(s), certification(s), any change in my medical staff/employment status at any facility, any change in my professional liability insurance coverage, or the filing of a lawsuit against me.

Signature	Date
Witness	Date

Privacy Act Notice

Authority: The authority for collection of information including social security number (SSN) is found in the Privacy Act of 1974, 5 U.S.C. § 552a.

Purpose: This form provides the advice required by the Privacy Act of 1974. The personal information will facilitate and document our verification of your credentials. The SSN and date of birth for the member is required to identify and retrieve credentials verification documents.

Routine Uses: The primary use of this information is to provide, plan, and coordinate member's credentials and privileging information. This will aid the privileging authority to review the member's academic qualifications, make a determination of the member's clinical competence, and grant appropriate privileges requested.

Disclosure: For all personnel, the requested information is mandatory because of the need to document all credentials and privileging data. Furnishing this information (including your SSN) is voluntary; however, if the requested information is not furnished, establishment of eligibility and granting of privileges will not be possible. This information may be used by and disclosed to Department of Homeland Security (DHS) and Department of Defense (DoD) personnel and contractors or other agents who need the information to assist in activities related to credentialing and privileging of healthcare providers.

Your signature acknowledges that you have been advised of the foregoing, that you authorize release of information from entities that can assist in verification of your credentials, including facilities where the applicant may currently hold privileges, individuals, and organizations that provide information concerning the applicant's participation in Coast Guard health care activities, allowing for primary source verifications, and that you hold the United States Coast Guard, the USCG Auxiliary, and any authorized individuals involved in the credentialing process and all individuals and organizations who provide information harmless as long as they are acting in good faith and without malice for actions taken during the credentials verification and privileging process.