House of Hope Medical Clinic
Application for Volunteer Licensed Health Care Providers

Name_____
(Last) (First) (Middle)
Date of Birth _____

Bus.Address_____ Home Address _____

_____ _____

Bus. Phone _____ Home Phone _____

Bus. Email _____ Home Email _____

EMERGENCY NOTIFICATION (Person to contact in case of emergency or illness)

Name_____ Relationship _____

Address_____

Phone number _____ Cell number _____

Please check appropriate title, status, specialty if applicable, and enter license or DEA number

Title: ___ Physician ___ NP ___ PA ___ RN ___ LPN ___ LMAC (acupuncturist)
___Chiropractor DC ___ Licensed Massage Therapist ____ Social Worker ____ Other
_____

Status: ___ Retired ___ Active Practice **Specialty:**_____

License Number_____ ____ Active ____ Inactive _____ Date Expires
(You must provide us with a copy of license)

DEA Number _____ Sponsor (PA's only) _____

VOLUNTEER SERVICE AVAILABILITY (Please complete this section)

I can serve___ hours ___ time(s) per week ___ time(s) per month ___ time(s) every other month

I prefer to be scheduled in the:_____ morning _____ afternoon _____ evening

Other/Consultation _____

The day(s) I prefer is (are) _____

ADDITIONAL INFORMATION: Further explanation of your specific skills, interests and/or preferences

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_____

_____

REFERRAL PATIENTS:

I will see referral patients in my private office _____ free of charge _____will set up a payment plan

I prefer to see the following number of patients: ____ per week ____ per month ____every other month

I prefer to only take patients on a case-by-case basis: _____

IMMUNIZATION:

Please complete the following regarding your position on Hepatitis B vaccination and Tuberculosis testing:

Hepatitis B: date of last vaccination_____ would like vaccination_____ decline vaccination_____

Tuberculosis: date of last test _____ would like testing _____ decline testing _____

LICENSING:

Physicians and Chiropractors must possess a valid medical license in any jurisdiction in the US as required for his/her discipline or specialty. For those with an out-of-state license, we will guide you toward acquiring a Special Maryland Medical License to work in a free health clinic.

Nurses, Nurse Practitioners, Physician Assistants and all other licensed health care professionals must possess a valid license in the state of Maryland as required for his/her discipline or specialty.

MALPRACTICE INSURANCE COVERAGE:

All Health Care Providers volunteering in the House of Hope Medical Clinic will have the option to be covered by FTCA coverage through the federal government.

Providers waiving their right to tort claim protection from the federal government will be required to provide the House of Hope Medical Clinic with proof of malpractice coverage.

Have you ever had any malpractice claims filed against you? Yes_____No_____
If you have, please attach one or more sheets detailing any claims, including dates, and the resolution and/or settlement of the claims.

CREDENTIALING:

All Volunteer Health Care Providers must be credentialed by the appropriate Licensing Board in Maryland

Please check all that apply:

_____ I am a member in good standing on the medical staff of _____

_____ I am applying for FTCA coverage through the House of Hope Medical Center.

SIGNATURE:_____ DATE _____