

Shared Care Free Health Clinic Volunteer Application

Date: _____ Volunteer Position: _____

NAME: _____

Mailing Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Fax : _____

E-Mail: _____

Current Occupation: _____

Emergency Contact: _____

Languages spoken other than English: _____ Date of Birth _____

For Medical Personnel (Please provide dates)

Tetanus: _____ Hepatitis B Series _____

History of Chicken Pox: _____ PPD _____

PLEASE PROVIDE **COPY** OF MEDICAL LICENSE

License State _____ Number _____ Expiration date _____

Board Certification _____ Date _____

Health Care Education _____

Degree Year _____ Area of Specialty _____

Current employer _____

Most recent hospital where you have had privileges or worked _____

Name, address, phone number for 3 references currently in practice in the KC metro area.

1. _____

2. _____

3. _____

Please answer the following questions. For any “yes” answers, please provide an explanation.

Have your privileges at any hospital been denied, suspended, revoked or not renewed, or is there any action pending in that case? Yes No

Have you been involved in any liability action, or is there action pending in such a case? Yes No

Have you been charged or convicted of a drug related misdemeanor or felony, or is there action pending in such a case? Yes No

Have you been asked to make any reform or compromise in connection with the Drug Enforcement Administration, or is there action pending in such a case? Yes No

Have you been censured by any hospital, County/state, medical society or is there action pending in such a case? Yes No

Has there been any restriction in your state licensure, or is there action pending in such a case? Yes No

Do you have a physical or emotional condition, including alcohol or drug dependence, which may affect or is likely to affect your ability to perform your professional duties? Yes No

Explanation:

ACCEPTANCE OF APPOINTMENT

I hereby accept appointment to the volunteer medical staff of Shared Care Free Health Clinic. I agree to abide by the rules and regulations of the clinic. All information submitted by me in this application is true to the best of my knowledge and beliefs. I agree to maintain the utmost professional behavior and to abide by the laws and duties regarding patient privacy.

Signature of Applicant

Date