COACHELLA VALLEY VOLUNTEERS IN MEDICINE
APPLICATION FOR LICENSED VOLUNTARY SERVICE PROVIDER

General Information

Thank you for your interest in volunteering.

Our ability to provide care is determined by the number of medical and dental providers such as you who give so freely of your time. Before completing our application please consider some of our requirements to be a volunteer.

1. All licensed providers, regardless of your profession, must be licensed to practice in the State of California.
2. All licensed providers are credentialed, a process that can take up to 8 weeks. Generally, you are not allowed to provide care at our Clinic until this process is completed.
3. Prior to submitting your application, we generally require you to shadow a current provider to experience firsthand some of what you will encounter as a provider.
4. If you decide to proceed with an application, we require a commitment to volunteer a minimum of 4 hours per month, for a minimum of at least 6 months.

If you are interested in continuing with your application, please answer the following questions to help us better meet your needs and desires.

Is there a particular program you are interested in? (Check all that apply)

- ☐ Direct patient care
- ☐ Street Medicine/Homeless Medical Outreach
- ☐ Residency program/preceptor
- ☐ Health Education/Wellness Programs
- ☐ Case Management Services
- ☐ Clinical lab/Medical Record Review/Audits

Are you bilingual Spanish? ☐ Yes ☐ A little ☐ Not at all

Please complete the following application and return it to us. You may also complete the application online at www.cvvim.org.

COACHELLA VALLEY VOLUNTEERS IN MEDICINE

APPLICATION FOR LICENSED VOLUNTARY SERVICE PROVIDER

INSTRUCTIONS: *Please type or print legibly in black ink***.** If more space is needed, attach additional sheets.

Is this a New Application? ☐ Complete All Sections and the New Provider Questions

Is this a Renewal Application?: ☐ Complete only Sections 1, 2, 6, 7 (as applicable)

When complete fax to (760) 342-4401 or email to info@cvvim.org. This form is also available for online completion at cvvim.org.

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1. IDENTIFYING INFORMATION

Last Name _____ First Name _____ Middle Initial _____ _____/_____/_____ Social Security No.

Office Address _____ City _____ State _____ Zip _____ Phone _____

Home Address _____ City _____ State _____ Zip _____ Phone _____

Cell Phone _____ Email Address _____ Birthdate _____

Primary Specialty _____ Secondary Specialty _____

Status: MD ❑ DO ❑ DPM ❑ DDS ❑ Dentist ❑ PA ❑ F/NP ❑ RN ❑ LVN ❑
Pharmacist ❑ Dietician (RD) ❑ Dental Assistant ❑ Dental Hygienist ❑ Other ❑ _____

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2. LICENSURE

CA License Number _____ Date Issued _____ Expiration Date _____

DEA Number (if applicable) _____ Date Issued _____ Expiration Date _____

Please attach a copy of CA Professional License, DEA License (if applicable)and Driver's License with this application.

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3. PROFESSIONAL EDUCATION

Institution _____ City and State _____ Degree _____ Date From _____ Date To _____

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4. POST GRADUATE TRAINING: INTERNSHIP(S)

Type of Internship _____ Specialty _____ Date From _____ Date To _____

Hospital _____ Address _____ City _____ State _____ Zip _____

RESIDENCY

Type of Residency _____ Date from _____ Date To _____

Institution _____ Address _____ City _____ State _____ Zip _____

5. BOARD CERT. Are you board certified? YES ❑ NO ❑

Name of Board	Date Certified/Recertified	Valid Through

6. HEALTH STATUS

IF THE ANSWER IS "NO" TO EITHER OF THE FOLOWING QUESTIONS, INCLUDE DETAILS AS AN ATTACHMENT.
Are you able to perform all the services required with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients?

YES ❑ NO ❑ *(If "no" or if reasonable accommodation is required please explain on a separate sheet)*

Are you able to safely perform all the essential mental and physical functions related to the care of patients at the CVVIM Clinic?

YES ❑ NO ❑

7. Disciplinary and/or Voluntary actions: Have any of the following ever been, or are currently being, denied, revoked, suspended, relinquished, withdrawn, reduced, limited, placed on probation, not renewed, or currently under investigation?

1. Clinical license in any jurisdiction? YES ❑ NO ❑
2. Other professional registration/license? YES ❑ NO ❑
3. DEA Certificate of registration or any applicable narcotic registration in any jurisdiction? YES ❑ NO ❑
4. Membership on any hospital medical staff? YES ❑ NO ❑
5. Clinical privileges, prerogatives/rights on any medical staff? YES ❑ NO ❑
6. Board Certification? YES ❑ NO ❑
7. Any other type of professional sanction? YES ❑ NO ❑
8. Have you been subject to any disciplinary action in any health care organization, or is any such action pending? YES ❑ NO ❑
9. Has any special monitoring requirements been imposed? YES ❑ NO ❑
10. Have you resigned or taken a leave of absence in order to avoid possible revocation, suspension, or reduction of privileges at any hospital or institution? YES ❑ NO ❑
11. Have there been, or are there any, misdemeanor or felony criminal convictions against you, or charges pending against you, or have you even taken "deferred adjudication" on any matter? YES ❑ NO ❑
12. **Have you had any malpractice cases filed against you over the past five years? YES ❑ NO ❑**
    If "yes" please provide details on Attachment "A" – Malpractice Claims Questionnaire, page 4

REQUEST TO PROVIDE VOLUNTARY SERVICES

By my signature below, I acknowledge that I have the burden of producing information requested by Coachella Valley Volunteers in Medicine for proper evaluation of my professional training, experience, competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications. I further acknowledge and agree that I will promptly and fully report all information to the CVVIM clinic in the event any of the answers above change, or if any situation arises which affects my ability to treat patients, after I have signed and dated this form. All the information contained in this application is complete and accurate to the best of my knowledge.

I pledge that I am free from any chemical dependency and physically and mentally able to practice medicine and perform the volunteer services I have requested. I agree to abide by clinic policies and procedures as from time to time may be revised or enacted.

CONSENT FOR RELEASE OF INFORMATION

I hereby authorize Coachella Valley Volunteers in Medicine, or their representatives, to consult with any entities or persons that may have information relative to my professional practice. **A photocopy of this waiver shall be as effective as the original when so presented. This consent shall remain in full force and effect for a period of two (2) years from the date signed below.**

I hereby release from any liability all those who, in good faith, review, act on, or provide information regarding my competence, training, experience, professional ethics, character, health status, and other qualifications, for providing volunteer services. I understand that the completion of this application is my sole responsibility.

I declare that the information furnished by me in this application is true and correct to the best of my knowledge.

Signature: _____

Print Name: _____ Date: _____

Attachment "A" - MALPRACTICE CLAIM/SUIT QUESTIONNAIRE

IF YOU HAVE ANSWERED "YES" TO SECTION 7, QUESTION 12 OF THE APPLICATION, PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE FOR EACH CLAIM OR SUIT: (If additional space is needed please use the reverse side of this form).

1. The date the claim was made or suit was filed. If you do not recall the exact date, please state the year:
   _____

2. Date the alleged incident, which the subject of the claim or suit occurred: _____
   _____

3. Name of claimant or plaintiff:_____

4. Name of all defendants known to you: _____
   _____
   _____

5. If the alleged incident occurred in a hospital, the name of the hospital:
   _____

6. Set forth a brief statement of the facts of the alleged incident and if the matter is pending, it's current status:
   _____
   _____
   _____
   _____
   _____
   _____

7. If the matter has been concluded (whether by settlement, judgment or dismissal) state the method of conclusion and the date: _____
   _____
   _____

8. If the matter has been settled, state the total amount of the settlement and any contribution made by you or your insurance carrier to the settlement: _____
   _____

9. If the matter is concluded by judgment for the plaintiff, the amount of the total judgment and any amount against you if different:
   _____
   _____

10. Also, state if the case was terminated by judgment in your favor or dismissal: _____
    _____

_____ _____

Name – Please Print Legibly Signature