COACHELLA VALLEY VOLUNTEERS IN MEDICINE

NEW APPOINTMENT APPLICATION

FOR LICENSED VOLUNTARY SERVICE PROVIDER

INSTRUCTIONS:

This form should be typed or legibly printed in black or blue ink. ***All questions must be answered***. If more space is needed, attach additional sheets and reference the question being answered. If a question does not apply to you, please mark as n/a. **When complete fax to 760 342 4401 or scan and email to info@cvvim.org**

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1. IDENTIFYING INFORMATION

_____ _____/_____/_____

Last Name First Name Middle Initial Social Security No.

_____

Current Office Address City State Zip Phone Fax

_____

Current Home Address City State Zip Phone Cell Phone

_____ _____/_____/_____

Email address Birth Date

_____

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

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actions: Have any of the following ever been, or are currently being, denied, revoked, suspended, relinquished, withdrawn, reduced, limited, placed on probation, not renewed, or currently under investigation?

Clinical license in any jurisdiction?	YES ❑ NO ❑
Other professional registration/license?	YES ❑ NO ❑
DEA Certificate of registration or any applicable narcotic registration in any jurisdiction?	YES ❑ NO ❑
Membership on any hospital medical staff?	YES ❑ NO ❑
Clinical privileges, prerogatives/rights on any medical staff?	YES ❑ NO ❑
Board Certification?	YES ❑ NO ❑
Any other type of professional sanction?	YES ❑ NO ❑
Have you been subject to any disciplinary action in any health care organization, or is any such action pending?	YES ❑ NO ❑
Has any special monitoring requirements been imposed?	YES ❑ NO ❑
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 ❑
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 ❑
Have you had any malpractice cases filed against you over the past five years? If "yes" please provide details on Attachment "A" – Malpractice Claims Questionnaire	YES ❑ NO ❑

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: _____

Revised November 2014

Attachment "A" - MALPRACTICE CLAIM/SUIT QUESTIONNAIRE

IF YOU HAVE ANSWERED "YES" TO QUESTION 12-H 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