

COACHELLA VALLEY VOLUNTEERS IN MEDICINE

REAPPOINTMENT 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**

1. IDENTIFYING INFORMATION

			/ /												
Last Name	First Name	Middle Initial	Social Security No.												
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 35%; border-bottom: 1px solid black;"></td> <td style="width: 15%; border-bottom: 1px solid black;"></td> <td style="width: 15%; border-bottom: 1px solid black;"></td> <td style="width: 15%; border-bottom: 1px solid black;"></td> <td style="width: 15%; border-bottom: 1px solid black;"></td> <td style="width: 20%; border-bottom: 1px solid black;"></td> </tr> <tr> <td style="text-align: center;">Current Office Address</td> <td style="text-align: center;">City</td> <td style="text-align: center;">State</td> <td style="text-align: center;">Zip</td> <td style="text-align: center;">Phone</td> <td style="text-align: center;">Fax</td> </tr> </table>										Current Office Address	City	State	Zip	Phone	Fax
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	/ /														
Email address	Birth Date														
Primary Specialty		Secondary Specialty													
Status: MD <input type="checkbox"/> DO <input type="checkbox"/> DPM <input type="checkbox"/> DDS <input type="checkbox"/> Dentist <input type="checkbox"/> PA <input type="checkbox"/> F/NP <input type="checkbox"/> RN <input type="checkbox"/> LVN <input type="checkbox"/> Pharmacist <input type="checkbox"/> Dietician (RD) <input type="checkbox"/> Dental Assistant <input type="checkbox"/> Dental Hygienist <input type="checkbox"/> Other <input type="checkbox"/> _____															

2. LICENSURE

CA License Number	Date Issued	Expiration Date						
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 45%; border-bottom: 1px solid black;"></td> <td style="width: 25%; border-bottom: 1px solid black;"></td> <td style="width: 30%; border-bottom: 1px solid black;"></td> </tr> <tr> <td style="text-align: center;">DEA Number (if applicable)</td> <td style="text-align: center;">Date Issued</td> <td style="text-align: center;">Expiration Date</td> </tr> </table>						DEA Number (if applicable)	Date Issued	Expiration Date
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3. BOARD CERT.

Are you board certified? YES NO

Name of Board	Date Certified/Recertified	Valid Through

4. 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 CVIM Clinic?

CVVIM Reappointment Application

Name: _____

YES NO

CVVIM Reappointment Application

Name: _____

5. 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? YES NO
If "yes" please provide details on Attachment "A" – Malpractice Claims Questionnaire

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

CVVIM Reappointment Application
Name: _____

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