EDWARD R. LEAHY JR. CENTER
CLINIC FOR THE UNINSURED

A PARTNERSHIP WITH THE UNIVERSITY OF SCRANTON

VOLUNTEER PHYSICAL THERAPY PROFESSIONALS INITIAL INFORMATION

A. Personal Data

Name:

Mailing address, home: (REQIURED)

Date of Birth _____

Home Phone # (Required): _____

Mobile # _____

Fax # _____

Email address _____

(Email is the preferred source of communication with the Leahy Clinic)

Are you currently in practice? □ Yes □ No Where? _____

If No, please explain why_____

B. Educational/Training History: (Please begin with the most recent)

Institution/location	Degree	Dates attended
Institution/location	Degree	Dates attended
Institution/location	Degree	Dates attended
Institution/location	Degree	Dates attended

C. Volunteer Interest

□ I would like to volunteer at the Leahy Center Clinic on Tuesdays/Thursdays (Circle):

- □ Weekly
- □ Monthly
- □ Every other week
- □ Other _____

□ I would like to volunteer at the Leahy Center Clinic from:

- □ 2pm to 4:30pm
- □ 4pm to 7pm
- □ 2pm to 7pm
- □ Other _____

D. Professional Data

Pennsylvania License # and expiration date:_____

Board Certified? □ Yes □ No

Name of Board and expiration date: _____

Teaching positions (past, present), if any:

E. Other Information:

1. **Have you ever been convicted of a misdemeanor or felony? □Yes □No**
2. **Are you aware of any circumstances which may affect or are likely to affect your ability to perform your professional duties? □ Yes □No**
3. **Have your privileges at any hospital been denied, suspended or revoked or not renewed, or is any such action pending? □ Yes □ No**
4. **Have you been censored by any hospital, county/state, medical society, or is any such action pending? □ Yes □ No**
5. **Has your malpractice insurance ever been denied or cancelled? □ Yes □ No**
6. **Are there any restrictions on your state license, in the past or present, or is any such action pending? □ Yes □ No**
7. **Have you been involved in any professional claims, suits, settlements or judgments, or are any such actions pending? □ Yes □ No**

If the answer to any of these 7 questions is YES, explain below or attach additional pages.
Allegations:

Specialty Involved:
Action taken:

Final outcome:

Malpractice/professional liability coverage
Do you currently carry malpractice insurance? □ Yes □ No
If yes, please complete the below

Name of company

Policy number_____

Contact person & phone_____

Amount_____

Expiration Date_____

Along with this application include the following as REQUIRED for the deeming process for the Federal Tort Claims Act (FTCA) coverage:

- □ **Social Security Number: _____**
- □ **Current of Copy State License**
- □ **Copy of a government issued picture ID (PA drivers or passport)**
- □ **Health fitness statement attesting to your ability to perform requested privileges**
- □ **Immunization and TB screening status (PPD or Quantum Interferon) (this may be included in health fitness statement)**
- □ **Copy of current CPR training**
- □ **Copy of the PA State Police Clearances and PA Child Abuse Clearance**
- □ **Copy of current malpractice insurance**

Volunteer Agreement: Release of Information

1. Professional liability insurance: I authorize and consent for the Leahy Center Clinic to obtain from my liability insurance carrier any and all information regarding insurance coverage, premiums, claims and suits against me as well as settlements or judgments made on my behalf.

2. Credentials and hospital privileges: I authorize and consent for the Leahy Center clinic to inquire and obtain documents that verify my credentials and staff privileges from the hospital(s) listed in Section D.

3. I authorize the Leahy Clinic to query my education institution to verify my professional education.

Signature (Please do not type) _____

Date: _____