EDWARD R. LEAHY JR., CENTER
CLINIC FOR THE UNINSURED

VOLUNTEER APPLICATION

□ **NURSING**
□ **PHARMACY**
□ **INTERPRETER LANGUAGE-_**
□ **OTHER_____**

A. Personal Data

Name:

HOME Mailing address (REQIURED):

Office/business mailing address:

Date of Birth: ---/---/------

Home phone # (REQIURED): ( ) _____

Mobile # ( ) _____

Office phone #: ( ) _____

Fax # _____

Email address _____

(E-mail is the preferred source of communication with the Leahy Clinic)

Are you currently in a professional practice? □ Yes □ No

Of yes, Where? _____.

Employers Address_____

Employers Phone Number (_____) _____-_____

B. Educational/Training History

Education (Please begin with the most recent) (Insert CV or Resume)

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

□ I would like to volunteer at the Leahy Center Clinic on Thursdays 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: _____

Specialty Practiced: _____

E. Other Information required by HRSA FTCA for malpractice coverage while working in the Leahy Clinic:

In the **past 10 years**:

1. Have you 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 and licensure 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:

F. Malpractice/Professional Liability Coverage
Do you currently carry malpractice insurance? □ **Yes** □ **No**
If yes, please complete the below (or provide a current copy)

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:

□ **Copy of Current State License**
□ **Copy of professional certification or diploma**
□ **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 (this may be included in health fitness statement)**
□ **Copy of current CPR training**
□ **Social Security number (to be used for the purpose of clearances provided by the Clinic _____-____-_____**

□ **Copy of the PA State Police Clearance, PA Child Abuse Clearance, FBI**
□ **Copy and explanation of any malpractice claims for the past 10 years**

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. I authorize and consent for the Leahy Center Clinic to do a query the National Provider Data Bank.

3. I authorize and consent to the Leahy Center Clinic to verify by professional education and licensure.

Signature Date