**VOLUNTEER HEALTH CARE PROVIDER (MD, DO, CRNP)**

**APPLICATION FOR VOLUNTEER PRIVILEDGES**

This initial application is intended to assist the Leahy Clinic in credentialing and privileging you within the clinic and with HRSA as a public health employee for the purpose of malpractice coverage under FTCA while practicing medicine in this clinic.

All information is maintained is a secure file and accessed by University of Scranton staff who are responsible for the credentialing process.

**You may submit a resume or CV with the required information.**

**A. Personal Information**

Name:

**Home** Mailing Address: (REQIURED by HRSA FTCA)

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone # : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile # (Required): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Are you currently in practice?**  Yes  No

If No, please explain why\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Name of Office Practice Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Address:

Contact person **in your office**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently have hospital privileges? Yes  No

Please list hospitals:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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If you are currently not practicing, or retired, did you have hospital privileges? Yes  No

**Please list hospitals:**

# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**B. Educational/Training History: (or Please Insert CV or Resume)**

**Premedical Education**

Institution Degree Dates attended

**Medical School**

Institution Degree Dates attended

**Internship**

Institution/location Dates served

**Residency**

Institution/location Dates served

**C. Professional Data**

Pennsylvania Medical License #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

NPI #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DEA#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Board Certified?  Yes  No Name of CertifyingAss:

**D. Volunteer Interest**

 I would like to volunteer to provide **primary care** at the Leahy Center Clinic Thursday afternoon (2 pm to 7 pm). I would like to volunteer

 every 2 weeks

 every 4 weeks

 4 times per year (quarterly)

 Other

I am to providing care to (check all that apply)

 Children

 Adolescents

 Adults

 Elderly

**E. Other Information: In the past 10 years**

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**

1. **Have you been involved in any professional claims, suits, settlements or judgments, or are any such actions pending?**  **Yes**  **No**

***If you answer YES to any question, explain below or attach additional pages. (It is a HRSA FTCA requirement to report).***

Allegations:

Specialty Involved:

Action taken:

Final Outcome:

**Personal Malpractice/Professional Liability Coverage.**

**Do you currently carry malpractice insurance? (Provide a copy)**

**Name of Company**

Policy number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Include the following as required for the deeming process for Federal Tort Claims Act (FTCA) coverage:**

**CHECKLIST OF REQUIRED DOCUMENTS**

 Current of Copy State Professional License

 Current Copy of DEA Registration number

 NPI number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Copy of Professional Certification and Diploma

 Copy of Current Professional Liability Insurance

 Copy of a government issued picture ID (PA drivers or passport)

 Health fitness statement attesting to your ability to perform requested privileges (form attached)

 Immunization and TB screening status (this may be included in health fitness statement)

(We strongly suggest an annual influenza vaccine and TB screening annually.)

 Copy of current CPR/AED training, if applicable

□ Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(For PA Criminal background Clearances)

□ Completed application for Child Abuse Clearance.

(The clinic will process the request).

**Volunteer Physician 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 and consent for the Leahy Center Clinic to do a query of the National Provider Data Bank.
4. I authorize and consent for the Leahy Center Clinic to verify my professional education and licensure with accrediting institutions and boards.
5. Authorization And Release of photographs and images

I hereby authorize the University of Scranton (University) to record my likeness and voice in video, audio, photographic, digital, electronic or any other medium.

I hereby grant the University the right and permission to copyright, use, reproduce, exhibit, distribute or publish in any medium, recordings, made for me for any purpose that the University deems appropriate, including educational, promotional and or advertising purposes.

I hereby waive any right that I may have to inspect or approve the unedited or edited likeness and or recording of myself.

I hereby release the University, its trustees, officers, agents, and employees from any liability by virtue of any blurring, distortion or alteration that may have occurred in the making of such images and from any liability for any violation of any personal or proprietary right I may have in connection with such use. I understand that all such recordings, in whatever medium, shall remain the property of the University.

I hereby warrant that I am eighteen years of age or older and have every right to contract in my own name and/or my child’s name. I have read and understand the foregoing.

**Print Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature (**Please do not type) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**