LICENSED PROFESSIONAL VOLUNTEER APPLICATION

➢ *Contact Information*

Name: _____ DOB: _____ Last 4 SSN: ____ ____ ____ ____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Clinical Specialty/Subspecialty: _____

➢ Availability *(Please Check All That Apply)*:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Weekends

☐ Mornings ☐ Afternoons ☐ Evenings ☐ As Needed ☐ Special Events

➢ Professional Data

*Please read each of the following questions, marking "**Yes** or **No**". If the answer to any question is "**Yes**", please attach a separate sheet to this application providing a full and detailed explanation. Thank you.*

Yes	No	
		Have any disciplinary actions been initiated or are any pending against you by any state licensure board?
		Has your license to practice in any state ever been denied, limited, reduced, lost, suspended, revoked or relinquished (voluntarily or involuntarily?
		Have you ever been sanctioned, lost, barred, excluded, investigated, suspended or otherwise restricted from participating in any private, federal or state health insurance programs (example: Medicare/Medicaid)?
		Have you ever been the subject of an investigation by any private, federal or state agency concerning your participation in any private, federal or state health insurance program?
		Has your Federal DEA certificate or any State Controlled Substance Certificates, including Indiana be voluntarily or involuntarily suspended, denied, limited, reduced, lost, relinquished or revoked?
		Is your Federal DEA or any State Controlled Substance Certificate, including Indiana currently being challenged?
		Have you ever, at any time, been charged and arrested for a felony?
		Have you ever been denied membership in a managed care plan?
		Has any information been submitted, or currently in process of being submitted, on you to the National Practitioner Data Bank?

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➢ Educational Data

Schools:

College/University	Degree	Date of Graduation

Internship/Residency/Fellowships:

Location/Name of Site	Type	Dates of Affiliation

➢ Health/Fitness Statement

*Please read each of the following questions, marking "**Yes** or **No**". If the answer to any question is "**Yes**", please attach a separate sheet to this application providing a full and detailed explanation. Thank you.*

Yes	No	
		Have you had or presently have any problems with alcohol, illegal substances or drug dependency?
		Are you currently taking any medications that may affect your clinical judgment or motor skills?
		Are you under any prescribed workload limitations?
		Have you any health problems (mental *or* physical) that may affect your ability to be available and to properly care for patients?
		Are you currently under the care of a physician for any condition that would affect your clinical practice?
		Do you have any physical, mental or emotional condition*(s)*, which would prevent you from performing all the functions and procedures associated with your privileges, with or without reasonable accommodation according to acceptable standards of professional performance and without posing a direct threat to patient care?

All information submitted by me to the Mel Leaman Free Clinic is true to my best knowledge and belief. I hereby agree to provide quality of care within the scope of my practice and demonstrate professional integrity while serving those individuals with no/limited insurance coverage.

Printed Name: _____ Date: _____

Signature: _____