Volunteer Physician Application

Name ______________________________ Date of Birth __________

Address ____

Office Phone ________________ Cell Phone __________________

Email ________________________

What is your current place of employment: ________________________________

What foreign languages can you speak? ________________________________

Which clinic(s) are you interested in volunteering at?

- ☐ IHS (Sumner Street): Mondays, 1:30 pm – 4:30 pm
- ☐ Pai'olu Kaiaulu Shelter (Waianae): 1st/3rd Tuesdays, 2:00 pm – 5:00 pm
- ☐ River Street (Chinatown): 2nd/4th/5th Tuesdays, 9:00 am – 12:00 pm
- ☐ Family Assessment Shelter (Kaka'ako Park): Thursdays, 5:00 pm – 8:00 pm
- ☐ St Mary's Church (King Street): Last Thursday, 10:00 am – 1:00 pm
- ☐ Hope Shelter (Kalaeloa): 1st Saturday of the month, 9:00 am – 12:00 pm
- ☐ First United Methodist Church (Beretania Street): Sundays, 8:30 am – 11:30 am (except 1st Sun)

How often would you like to volunteer at HOME clinic?______________________

HEALTH STATUS:

Yearly review of health status is required of all clinic volunteers for the health and safety of our patients.

		Yes	No
1.	Do you currently have any physical or mental impairments that could limit your clinical practice?	☐	☐
2.	Do you have a potentially communicable disease?	☐	☐
3.	Have you been hospitalized for any reason during the last 5 years?	☐	☐
4.	Are you currently or have you ever been under formal mental health therapy?	☐	☐
5.	Are you currently under or have you ever received treatment for an alcohol or drug related condition?	☐	☐
6.	Have you ever been involved in the unlawful use of controlled substances?	☐	☐

Comments: ____

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AUTHORIZATION TO RELEASE VOLUNTEER INFORMATION

Your consent is requested for the following information:

1. I authorize the Hawaii H.O.M.E. Project to print my name as a volunteer in information produced and distributed by the organization or the University of Hawaii John A. Burns School of Medicine.

   ☐ **YES** ☐ **NO**

2. I authorize the Hawaii H.O.M.E. Project to use pictures/videos of me while in the service of the clinic for the use of promoting the project and/or its mission

   ☐ **YES** ☐ **NO**

Educational/Training History:

Medical School	City & State	Year Graduated	Degree

Residency	City & State	Year Completed

Fellowship	City & State	Year Completed

Primary Specialty: ________________________________

Board Eligible: ☐ Yes ☐ No Board Certified: ☐ Yes ☐ No

Secondary Specialty: ________________________________

Board Eligible: ☐ Yes ☐ No Board Certified: ☐ Yes ☐ No

Hawaii Licensure Number: __________________ Expiration Date: _____________

NPI #: ____________________________________

PLEASE ATTACH A COPY OF THE FOLLOWING ITEMS WITH THIS APPLICATION:

1) Current medical license
2) Current State narcotics license
3) Current federal DEA license
4) Current CV
5) Driver's license or other picture ID

Please answer the following questions. Positive responses (Yes) require a written explanation attached to this document.

Questions:	Yes	No
1. Has your license to practice medicine ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or has been subject to a fine, reprimand, consent order, or probation?	☐	☐
2. Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?	☐	☐
3. Have you ever been terminated for cause or not reviewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?	☐	☐
4. Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?	☐	☐
5. Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental Healthcare programs?	☐	☐
6. Have you ever been suspended, fined, disciplined, sanctioned, or otherwise restricted or excluded from participating in any private health insurance program?	☐	☐
7. Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program?	☐	☐
8. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank to Healthcare Integrity and Protection Data Bank?	☐	☐
9. Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g. CLIA, OSHA, etc.)?	☐	☐
10. Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your liability history?	☐	☐
11. Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your liability history?	☐	☐
12. Have you ever had any professional liability actions (pending, settled, arbitrated, mediated, or litigated) within the past 10 years? If yes, provide information on each case.	☐	☐
13. Have you ever been denied liability insurance coverage?	☐	☐
14. Are there any professional liability (i.e. malpractice) claims, suits, judgments, settlements, or arbitration proceedings, involving you currently pending?	☐	☐
15. Have you ever been accused of sexual harassment or other illegal misconduct?	☐	☐
16. Have you ever been convicted of, pled guilty to, or pled no contest to any felony?	☐	☐

I have checked with my malpractice carrier and I am covered for volunteer clinical services

☐ Yes ☐ No

****If No, by signing here, I am acknowledging that the Hawaii H.O.M.E. Project does not supply malpractice coverage for me and that I am only protected to the extent allowable by the Federal Tort Claims Act.**

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Signature

By signing below, I attest that all of the information provided on this application is accurate.

________________________________ ____________________

Signature Date

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Printed Name

Professional References

Reference #1:
Name: ____
Address: ____
Phone: ______________________ **Email:** ____________________

Reference #2:
Name: ____
Address: ____
Phone: ______________________ **Email:** ____________________

Reference #3:
Name: ____
Address: ____
Phone: ______________________ **Email:** ____________________