

**LICENSED PHYSICIAN VOLUNTEER APPLICATION**

**NAME:**

**Date:**

**ADDRESS:**

**CITY:**

**STATE:**

**ZIP:**

**PHONE:**

**E-MAIL:**

**Employer:**

**BIRTHDAY:**

**S.S.#**

**needed for FTCA Malpractice**

**NPDB Credentialing or you are welcome to self-Query and give the clinic a**

**copy <https://bphc.hrsa.gov/ftca/freeclinics/policies.html> Free Clinic Policy**

**Guide**

**AVAILABLE HOURS**

- mornings
- afternoons
- evenings
- special events

**Days I am available: M T W TH F**

**Two References (Not Relatives)**

**Name:**

**Address:**

**Telephone:**

**Name:**

**Address:**

Telephone:

**PROFESSIONAL DATA**

Clinical Specialty/Subspecialty:

Please answer each question. If the answer to any question is “yes” please provide a full explanation of details on a separate sheet and attach to this application

Yes    No

		Do you presently use any drugs illegally?
		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 Idaho be voluntarily or involuntarily suspended, denied, limited, reduced, lost, relinquished or revoked?
		Is your Federal DEA or any State Controlled Substance Certificate, including Idaho currently being challenged?
		Have you ever, at any time, been charged and arrested for a felony?
		Has any information been submitted, or currently in process of being

		submitted, on you to the National Practitioner Data Bank?
		Have you ever been subject to review, challenges, and/or disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, professional association or education/training institution?
		Are you currently under governmental investigation?
		Have allegations or claims of professional negligence been made against you at any time, whether or not you were individually named in the claim or lawsuit?
		Have you or your insurance carrier(s) ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgement (court ordered damage award) in a professional lawsuit?
		Are there any such claims being asserted now?
		Have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted limited, surcharged)?

**EDUCATIONAL DATA**

**College/University**

**Degree**

**Date of Graduation**


**Internship/Residency/Fellowships:**

Location	Type	Dates of Affiliation

**License Number** \_\_\_\_\_

**NPI Number** \_\_\_\_\_

**Drug Enforcement Agency Administration #** \_\_\_\_\_

**Date Expires** \_\_\_\_\_

**ISB Pharmacy Registration Number** \_\_\_\_\_

All information submitted by me to The Marie Blanchard Friendship Clinic, INC, 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 medical or healthcare coverage.

**Signature:**

**Date:**

**Printed Name:** \_\_\_\_\_

**Additional Information need for our Mal-Practice Insurance through the Federal Tort Claims Act: <https://bphc.hrsa.gov> Under Free Clinics**

- 1. Identification (government issued picture ID)**
- 2. Current life support training (if you have it)**
- 3. Rubella, Rubeola, Varicella, and Hepatitis B antibody titers; TB skin or blood test results, and proof of Tdap immunization**

#### **4. Complete Annual Malpractice form**

##### **Office Use Only**

Review Dates & Initials