THE MARIE BLANCHARD

FRIENDSHIP CLINIC

Your Bridge to Health

LICENSED PROFESSIONAL VOLUNTEER APPLICATION

NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE: _____ **CELL:** _____

E-MAIL: _____

BIRTHDAY: _____

AVAILABLE HOURS

- **mornings**
- **afternoons**
- **evenings**
- **special events**

Days I am available: M T W TH F Weekends

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	
		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?

EDUCATIONAL DATA

College/University	Degree	Date of Graduation

Internship/Residency/Fellowships:

Location	Type	Dates of Affiliation

License Number _____ **Date Expires** _____

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 (attached)