

Name: _____

Clinic: _____



Volunteer Nurse Practitioner Application

AmeriCares Free Clinics, Inc.

88 Hamilton Avenue, Stamford, CT 06902

Phone: (203) 658-9500 ~ Fax: (203) 406-4445

Email: freeclinics@americares.org

www.americaresfreeclinics.org

Application Checklist

Please complete the application and mail or fax it to the above address along with the following documentation:

1. Copy of Connecticut license.
2. Copy of NP Certification
3. For NPs NOT on staff at one of our partner hospitals (Norwalk, Danbury, Bridgeport or St. Vincent's), a letter of recommendation from your current/former employer or medical colleague.
4. For NPs retired more than two years – evidence of some continuing work in a related field.
5. Copy of DEA license (state and federal) – *if retired, optional*.
6. Curriculum Vitae (optional).

Date: _____

Clinic: _____

Personal Information

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Birth date: (m/d/y) _____ SS#: _____

Phone-Home: _____ Office: _____ Cell: _____

Email: _____ Emergency Contact: _____
Name/Phone

Do you speak any other languages? _____

Are you currently employed? _____ If retired date of retirement: _____

If currently employed: Employer: _____ Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred AFC Clinic Site: Bridgeport Clinic Danbury Clinic Norwalk Clinic

Availability: Please check days and times that you are available

Sessions	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
9-12 am					Closed	
12-4 pm					Closed	
4-7 evening					Closed	

How did you hear about our program? Please Check:

- Another volunteer Radio/ TV AFC website Volunteer website
 Newspaper/ other print AmeriCares staff or board Other

Current Practice

Connecticut NP License #: _____

Date Licensed: _____ Expiration Date: _____

Federal DEA # _____ Expiration Date: _____

Are you licensed in any other states?

State: _____ License # _____ Expiration Date: _____

Education

NP Program: _____
Name of School

City: _____ State: _____

Year Graduated: _____ Degree: _____ Specialty Type: _____

Number of CME credits last year? _____ Past 2 years: _____

Please list the professional organizations in which you are a member:

Please attach CV or answer the following:

Where have you practiced your profession in the last eight (8) years? Include military or any public service and any gaps in practice. (Attach a separate sheet if needed.)

City/State	From (m/y)	To (m/y)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list the hospitals where you have privileges, their address and your status (attach a separate sheet if needed).

Hospital	City/State	Status
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please answer the following questions: **

1. Have you ever been investigated, disciplined, censured, or reprimanded by a medical society, professional review board, or state licensing entity or board or had a complaint against you submitted to any such entities? Yes No
2. Have you ever had your membership in any professional society or association refused, suspended, revoked, or received any criticism or reprimand from any specialty society? Yes No
3. Have your hospital privileges ever been restricted, denied, suspended, revoked, or has any disciplinary action been taken against you? Yes No
4. Has your medical or DEA license ever been restricted, voluntarily surrendered, suspended or revoked? Yes No
5. Have you ever been charged with a felony or misdemeanor other than minor traffic offenses? Yes No
6. Do you have any personal health problems that might affect your ability to safely practice medicine? Yes No
7. Have you ever filed a long-term disability claim where the claimed disability impacted your ability to perform any aspect of your medical practice? Yes No
8. Are you currently or have you ever been treated for a psychiatric condition, alcoholism or substance abuse? Yes No

****If you answered yes to any of the above questions, please explain in a separate letter.**

Insurance and Claims History

1. List previous med. professional liability policies for the past 8 years:

(Use separate sheet if needed)

Company	Policy	Limit	Policy Period	Retro Date	Premium	Claims Made	Occurrence

2. Has any insurer ever canceled, declined or reduced coverage (i.e., reduced limits, restricted coverage, surcharged rates, or refused renewal for this or any similar coverage)? Yes No

If "Yes," please provide details:

3. Have you ever submitted to a liability insurer or risk transfer instrument any claim or given notice of any fact, situation, transaction, event, act, error or omission for a malpractice claim, suit or incident, either directly or indirectly? Yes No

4. Other than claims or potential claims that have been previously reported, are you aware of any fact, circumstance, situation, transaction, event, act, error or omission which you know or reasonably should know may result in a claim that may fall within the scope of the proposed insurance? (For the purposes of this question, "reasonably should know" includes any act, error, omission or occurrence that alleged sexual, physical or emotional abuse or misconduct; or was the subject of any peer review; professional or specialty association, accreditation or licensing entity; local, state or federal investigation; JCAHO "near miss" investigation; sentinel event report or root cause analysis; incident report investigation; written notification, inquiry or demand by legal counsel or matter submitted to legal counsel; mandatory report on professional conduct; or similar investigation or review.) Yes No

If "Yes" to either question 3 or 4, **please describe each claim, suit, or incident** regardless of its outcome, on the Malpractice Claims Information form(s) at the end of this Application, and attach a carrier claim report from the past ten (10) years including amounts paid and reserved. Any Malpractice Claims Information forms and carrier claim reports are part of this Application.

Note: Without prejudice to any other rights and remedies of the underwriter, it is agreed that any claim, or related claim, arising out of any fact, circumstance, situation, transaction, event, act, error, or omission that is or should have been disclosed in response to Questions 3 or 4 is excluded from the proposed insurance.

Confidentiality Statement: I understand that in my capacity as a volunteer with the AmeriCares Free Clinics, I may come into contact with confidential information. I agree to protect this information to the best of my ability and not to divulge it during my volunteer service or after my volunteer service has ended. I consent to the use of my photograph for any media as it pertains to the AmeriCares Free Clinics program or AmeriCares.

The undersigned declares that the statements set forth herein are true. The undersigned agrees that if the information supplied on this application changes between the date of this application and the effective date of service, he/she will immediately notify the AmeriCares Free Clinics, Inc. The

undersigned understands that the AmeriCares Free Clinics, Inc. reserves the right to decline or dismiss a volunteer physician/nurse practitioner for just cause or reason.

In the event of any material untruth, misrepresentation or omission in connection with any particulars or statements in this application, any issued policy shall be void with respect to any insured who knew of such untruth, misrepresentation or omission or to whom such knowledge is imputed.

Applicant (please print)	
By (Signature)	Date:

Malpractice Claims Information

(To be completed in response to questions 3 & 4 on page 4)

1. Name of patient/claimant: _____ Sex: ____ Age: _____

2. Allegation and date of incident: _____

3. Location: _____

4. Your relationship to the patient (attending physician; APRN, etc.): _____

5. Insurance carrier and policy number: _____

Status	Amount	
Open- Reserve Amount	\$	
Closed – Loss Amount	\$	Date:
Settlement- Total Amount	\$	Your Portion: \$
Judgment- Total Amount	\$	Your Portion: \$

6. Other defendants: _____

7. Condition and diagnosis at the time of the incident: _____

8. Description of medical treatment rendered: _____

9. Condition of patient subsequent to treatment: _____

10. To whom may we refer to obtain further information regarding this claim or lawsuit? _____



Scope of Practice

The mission of the AmeriCares Free Clinics is to provide free quality medical care to the uninsured and the underinsured using volunteer professional staff. The Clinic's intention is to help those who are making a sincere effort to help themselves and their families, but have no financial resources for medical care.

The AmeriCares Free Clinics is an ambulatory care facility providing services for commonly occurring self-limiting acute illnesses, chronic conditions and certain preventative health/health maintenance needs of adults (and children in Norwalk). Potentially severe or emergent care situations will be referred to appropriate health care settings with the requisite facilities and equipment. Chronic conditions with the likelihood of severe or emergent complications will be referred to the appropriate facility for long term follow up.

Definitions of services provided: (These definitions are to serve as an example and by no means imply a complete listing.)

- **Self-limiting acute:** Upper respiratory infections, urinary tract infection, flu, sore throats, rashes, generalized pain
- **Chronic conditions:** Diabetes, hypertension, hypothyroidism, asthma, seasonal allergies, osteoarthritis
- **Prevention/health maintenance:** School or work physicals (excluding motor vehicle and foster child care), TB testing, immunizations (for children in Norwalk).
- **Procedures:** EKGs, venipuncture, minor incision and drainage without sutures
- **Specialty Clinics:** as available

Services provided in clinic:

- **Initial assessment of all presenting conditions**
- **Follow up care after initial assessment, if within the Scope of Practice**
- **Appropriate referrals to other health care providers. For example:**
 - ✓ Any emergency care – Call 911.
 - ✓ Any unstable acute or chronic illness – refer to a hospital emergency department.
 - ✓ Any condition with the likelihood of severe or emergent complications

Note: Any unstable chronic condition can be referred to an outside specialist for assessment and follow-up related to that condition while other basic health care is provided by AFC. For example: Mental health is referred, but other health needs are met at AFC.

In completing my orientation, I have reviewed and agree to work within the above Scope of Practice.

Signature

Date

Print Name

6/2010