

## AmeriCares Free Clinics, Inc.

88 Hamilton Avenue, Stamford, CT 06902  
Phone: (203) 658-9500 ~ Fax: (203) 658-9612  
Email: [freeclinics@americares.org](mailto:freeclinics@americares.org)  
[www.americaresfreeclinics.org](http://www.americaresfreeclinics.org)

### Volunteer Physician Application

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Office Address: \_\_\_\_\_ Town: \_\_\_\_\_ State/Zip: \_\_\_\_\_  
\_\_\_\_\_ Office # \_\_\_\_\_ Office Fax: \_\_\_\_\_  
Residence: \_\_\_\_\_ Town: \_\_\_\_\_ State/Zip: \_\_\_\_\_  
Home # \_\_\_\_\_ Home Fax: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Preferred place of contact: \_\_\_\_\_ Other Languages: \_\_\_\_\_  
How did you here about the clinic? \_\_\_\_\_

**Preferred AFC Clinic Site:**  Bridgeport Clinic  Danbury Clinic  Norwalk Clinic

**Availability:** Please check all the days and times that you are available:

	<u>Mon</u>	<u>Tues</u>	<u>Wed</u>	<u>Thurs</u>	<u>Fri</u>	<u>Sat</u>
A.M.	_____	_____	_____	_____	_____	_____
P.M.	_____	_____	_____	_____	_____	_____
Eve 4p- 7p	_____	_____	_____	_____	_____	_____

To complete the application process, the following items must be mailed or faxed to AmeriCares Free Clinics, Inc., 88 Hamilton Avenue, Stamford, CT 06902 ~ Fax (203) 658-9612.

1. Completed application (if you have any questions, please call Cathy at (203) 658-9654).
2. Copy of Connecticut license.
3. Copy of Board Certification in Internal Medicine, Family Practice, Emergency Medicine or Pediatrics (if applicable).
4. Letter of recommendation from the Department Head of your current/former employer, IF candidate is not known to the Clinic Medical Director; or is not on staff at participating hospital.
5. Evidence of some continuing work in a related field, IF retired more than two years.
6. Copy of DEA license (state and federal) – *if retired, optional*.
7. Curriculum Vitae (optional).

Once all application materials have been received and the credentialing process is complete, and the insurance company has approved your application, you will be notified as to when you volunteer service may begin.

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 (the undersigned) 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.

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.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

We thank you for your interest and look forward to working together!

\* This application is also used for APRN Volunteers.

Rev. 12/2008

Name of Applicant: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Federal DEA # \_\_\_\_\_ Exp. Date: \_\_\_\_\_

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**Education**

1. a. Medical School: \_\_\_\_\_  
Name of School City State

Year Graduated: \_\_\_\_\_ Degree:  M.D.  D.O.

b. Internship: \_\_\_\_\_  
Name of Hospital City State

From: \_\_\_\_\_ To: \_\_\_\_\_  
month/year month/year

c. Residency: \_\_\_\_\_  
Name of Hospital City State

Year completed: \_\_\_\_\_ Specialty Type: \_\_\_\_\_

d. Fellowship (if applicable): \_\_\_\_\_  
Name of Hospital City State

Year completed: \_\_\_\_\_ Specialty Type: \_\_\_\_\_

How many continuing medical education credits did you achieve last year? \_\_\_\_\_ Past 2 years: \_\_\_\_\_

2. Nurse Practitioners

NP Program: \_\_\_\_\_  
Name of School City State

Year Graduated: \_\_\_\_\_ Degree: \_\_\_\_\_ Specialty Type: \_\_\_\_\_

How many continuing education credits did you achieve last year? \_\_\_\_\_ Past 2 years: \_\_\_\_\_

**Current Practice**

Current Medical (or APRN) License #: \_\_\_\_\_ State: CT

Date Licensed: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Are you licensed in any other states? \_\_\_\_\_ State: \_\_\_\_\_ License # \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Other medical or professional licenses or certifications, including ECFMG (list states or countries, license numbers and dates): \_\_\_\_\_

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Are you Board Certified?  Yes  No If "No," are you Board Eligible?  Yes  No  
 Name(s) of approved specialty board(s)/certification(s): \_\_\_\_\_

Date of Certification: \_\_\_\_\_ Is re-certification required?  Yes  No

If "Yes," date of anticipated re-certification: \_\_\_\_\_

What professional organizations are you a member of: \_\_\_\_\_

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: month/year	To: month/year
_____	City/State	From: month/year	To: month/year
_____	City/State	From: month/year	To: month/year
_____	City/State	From: month/year	To: month/year
_____	City/State	From: month/year	To: month/year

List all hospitals where you currently have staff privileges (attach a separate sheet if needed).

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

Has your practice changed in the last eight (8) years?  Yes  No

If "Yes," please explain: \_\_\_\_\_

**Insurance and Claims History**

1. List previous medical professional liability policies for the past eight (8) years (list additional policies on a separate sheet):

_____	Company	Policy #	Limit	Policy Period	Retroactive Date	Premium	<input type="checkbox"/>	<input type="checkbox"/>
							Claims Made	Occurrence
_____	Company	Policy #	Limit	Policy Period	Retroactive Date	Premium	<input type="checkbox"/>	<input type="checkbox"/>
							Claims Made	Occurrence

Company	Policy #	Limit	Policy Period	Retroactive Date	Premium	<input type="checkbox"/>	<input type="checkbox"/>
						Claims Made	Occurrence

  

Company	Policy #	Limit	Policy Period	Retroactive Date	Premium	<input type="checkbox"/>	<input type="checkbox"/>
						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 reported to a previous liability insurer or risk transfer instrument, 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.**

### Professional History

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  
If "Yes," please explain: \_\_\_\_\_
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  
If "Yes," please explain: \_\_\_\_\_
3. Have your hospital privileges ever been restricted, denied, suspended, revoked, or has any disciplinary action / observation been taken against you?  Yes  No

If "Yes," please explain: \_\_\_\_\_

- 4. Has your medical or narcotics license ever been restricted, voluntarily surrendered, suspended or revoked?  
 Yes     No

If "Yes," please explain: \_\_\_\_\_

- 5. Have you ever been charged with a felony or misdemeanor other than minor traffic offenses?  
 Yes     No

If "Yes," please explain: \_\_\_\_\_

- 6. Do you have any personal health problems that might affect your ability to safely practice medicine?  
 Yes     No

If "Yes," please explain: \_\_\_\_\_

- 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

If "Yes," please explain: \_\_\_\_\_

- 8. Are you currently or have you ever been treated for a psychiatric condition, alcoholism or substance abuse?  
 Yes     No

If "Yes," please explain: \_\_\_\_\_

**Please disclose any information material to the risk that has not otherwise been addressed in this application. (Please attach additional sheets of paper if necessary.)**

**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.**

I agree to abide by the rules and regulations of the Administration, Volunteer Medical Director and Medical Advisory Committee, as well as any amendments added thereto.

I hereby declare that the above statements and particular are true and that I have not omitted or misstated any material facts and I agree that this Application shall be the basis for any insurance policy that is issued.

Applicant	
By (Signature)	Date

Applicant: \_\_\_\_\_

**Malpractice Claims Information**

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

1. Name of patient or 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: \_\_\_\_\_  
\_\_\_\_\_      Open – Reserve Amount      \$ \_\_\_\_\_  
\_\_\_\_\_      Closed – Loss Amount      \$ \_\_\_\_\_      Date Closed: \_\_\_\_\_  
\_\_\_\_\_      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?  
\_\_\_\_\_