

## Healthcare Provider Volunteer Application

Name:			Date:
Pronouns:			
Former name when attending	ıg school:		
Address:			_
Phone: (h)	(w)	(c)_	
Email:			
Are you currently in school?	□ No   □ Yes, grad	uating in	
In case of emergency, notify:	:	Relations	ship:
Phone: (h)	(w)	(c)	
Hours and days you are avail			
How often would you like to	volunteer?		
Can you provide healthcare i			
How did you learn about the	Open Door Clinic? _		
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Claims Act; Free Clinics Ins	surance Program. deemed (approve	In order for you to volued) by the FTCA gove	ment through the Federal Tort nteer with the clinic, you must rnment program. This takes ete this process:
Date of Birth:	S	ocial Security Number:	
School of Graduation:		Yea	r of Graduation:
School Address:			
			Occupation:
DEA #:	NPI	#:	
Employer Name & Address:			
Malpractice Insurance? □ N	o∣ □ Yes - Compan	y:	



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Do you have any malpractice claims against yo	ou, past or pending?   No     Yes – Please explain (attach
additional sheets if necessary)	
CPR Certified: □ No   □ Yes	
Please list the name, email, and phone number	er of three (3) professional references, including at least
two references who have worked with you in a	medical capacity (please, do not list relatives):
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·	o   🗆 Yes - Please explain (attach additional sheets if
necessary)	
Vour signature helow indicates your narmission	on to allow ODC staff to contact the references listed above
and that the information provided in this appli	
and that the information provided in this application	Edition is correct.
Signature:	Date:
Opportunities for volunteers are provided with	out regard to religion, creed, race, national origin, age,
sexual orientation, or gender.	

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