Clínica Esperanza/ Hope Clinic
60 Valley St., Suite 104
Providence, RI 02909
(401) 347-9093
www.aplacetobehealthy.org

Volunteer Provider Application

Dear Prospective Volunteer,

Thank you for your interest in volunteering with the Clínica Esperanza/Hope Clinic. The support we receive from volunteers enables us to accomplish our mission of providing quality care, at no charge, to people without access to basic health care. Attached is our volunteer application packet. Volunteers are required to complete an application and provide two professional references. Please complete the attached application packet, and return the following items at your convenience:

- Application
- Education verification form
- Two completed letters of reference (in separate sealed envelopes or emailed directly from the recommender)
- Copies of current licenses and/or certificates
- Immunization records
- Rhode Island state BCI

Please do not submit your application until all components have been completed fully. Feel free to contact the **Volunteer Coordinator at VCoordinator@aplacetobehealthy.org** or **Sharon Farrar RN, Associate Director of Clinical Services at SharonF@aplacetobehealthy.org** if you have any questions or need additional information regarding the volunteer program.

After your completed application is processed, you will be invited to attend both an orientation and specific training for your area of interest. You can also choose to shadow with a CEHC provider, if you wish. Again, thank you for your interest in volunteering for the Clínica Esperanza/Hope Clinic. We look forward to working with you.

Sincerely,

Morgan Leonard
Executive Director
Clínica Esperanza/Hope Clinic

Sharon Farrar RN
Associate Director of Clinical Services
Clínica Esperanza/Hope Clinic

Anne DeGroot, MD
Volunteer Director of Quality Assurance
Clínica Esperanza/Hope Clinic

Personal & Contact Information

Name: _____ Date: _____

Office Address: _____Town: _____State/Zip_____

Office email (if applicable): _____ Office #: _____

Office Fax: _____

Residence: _____Town: _____ State/Zip: _____

Home #: _____ Cell Phone: _____ Email: _____

Preferred place of contact: _____

Please list any other languages with proficiency levels:

_____

_____

_____

How did you hear about the clinic?

_____

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

	Mon	Tues	Wed	Thurs	Fri	Sat
A.M	____	____	____	____	____	____
P.M.	____	____	____	____	____	____

To complete the application process, the following items must be emailed, mailed, or faxed to Clínica Esperanza/Hope Clinic, 60 Valley Street, Suite 104, Providence, RI 02909 ~ Fax (401) 223-4844

1. Completed application
2. Copy of Rhode Island medical license.
3. Copy of Board Certification(s) in Internal Medicine, Family Practice, Emergency Medicine or Pediatrics, etc. (if applicable).
4. Letters of recommendation from the Department Head of your current/former employer, IF candidate is not known to the Executive Director; or is not on staff at a 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/Resume (*please be sure to include a 5-year work history*)
8. Evidence of Malpractice Insurance

9. ECFMG number_____ (if applicable)

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 your 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, the undersigned will immediately notify the Clínica Esperanza/Hope Clinic staff. The undersigned understands that the Clínica Esperanza/Hope Clinic 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 Clínica Esperanza/Hope Clinic, 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 Clínica Esperanza/Hope Clinic program.

Signature: _____ Date: _____

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

This application is also used for PA, DO, NP, RN, and APRN volunteers. Please complete the sections of the application that apply to your credentials.

Name: _____ Date of Birth: _____

Federal DEA # _____ Exp. Date: _____

Education

ALL APPLICANTS

Undergraduate: _____
Name of School City State

Type of degree awarded: _____ Year: _____

Graduate: _____
(*If applicable)* Name of School City State

Degree awarded: _____ Year: _____

MD/DO/PA-C

Medical School: _____
Name of School City State

Year Graduated: _____ Degree: ☐ M.D. ☐ D.O. ☐ PA-C

Internship: _____
Name of Hospital City State

From: _____ To: _____
month/year month/year

Residency: _____
Name of Hospital City State

Year completed: _____Specialty Type: _____

Fellowship (*if applicable*): _____
Name of Hospital City State

Year completed: _____ Specialty Type: _____

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: _____

Date Licensed: _____ Expiration Date: _____

Are you licensed in any other states? □ Yes □ No

State: ____ License # _____ Expiration Date: _____

Other medical or professional licenses or certifications? (List states or countries, license numbers and dates):

_____

_____

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

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	☐ 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/include 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, Executive Director, and Medical Advisory Board, 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.

Signature: _____ Date: _____

Applicant Name (print): _____

Revised 9/2023

Malpractice Claims Information
(To be completed in response to questions 3 & 4 on page 7)

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?

_____