



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

Volunteer Provider Application Packet

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 to me at your convenience:

- _____Application
- _____Two completed letters of reference (in separate sealed envelopes or emailed)
- _____Copies of current licenses and/or certificates

Please do not submit your application until all components have been fully completed. Feel free to contact Megan Spinney, Volunteer Coordinator [via email at VCoordinator@aplacetobehealthy.org](mailto:VCoordinator@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. Again, thank you for your interest in volunteering for the Clínica Esperanza/Hope Clinic. I look forward to working with you.

Sincerely,

Anne DeGroot, MD
Volunteer Executive Director
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 license.
3. Copy of Board Certification in Internal Medicine, Family Practice, Emergency Medicine or Pediatrics (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 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, 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 APRN Volunteers.***

Name of Applicant: _____ Date of Birth: _____

Federal DEA # _____ Exp. Date: _____



Education

Medical School: _____
Name of School City State

Year Graduated: _____ Degree: M.D. D.O.

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
_____	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	Claims Made	Occurrence
						<input type="checkbox"/>	<input type="checkbox"/>

						<input type="checkbox"/>	<input type="checkbox"/>
--	--	--	--	--	--	--------------------------	--------------------------

						<input type="checkbox"/>	<input type="checkbox"/>
--	--	--	--	--	--	--------------------------	--------------------------

						<input type="checkbox"/>	<input type="checkbox"/>
--	--	--	--	--	--	--------------------------	--------------------------

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, Volunteer Executive 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.

Signature: _____

Date: _____

Applicant Name (print): _____



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?
