FRIENDSHIP CLINIC

*Your Bridge to Health*

THE MARIE BLANCHARD

**LICENSED PROFESSIONAL VOLUNTEER APPLICATION**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_**

**PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**E-MAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**BIRTHDAY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last 4 # SS for FTCA Insurance\_\_\_\_\_\_\_\_\_**

[**https://bphc.hrsa.gov/ftca/freeclinics/policies.html**](https://bphc.hrsa.gov/ftca/freeclinics/policies.html) **Free Clinic Policy Guide**

**AVAILABLE HOURS**

* **mornings**
* **afternoons**
* **evenings**
* **special events**

**Days I am available: M T W TH F Weekends**

**PROFESSIONAL DATA**

**Clinical Specialty/Subspecialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please answer each question. If the answer to any question is “yes” please provide a full explanation of details on a separate sheet and attach to this application**

**Yes No**

|  |  |  |
| --- | --- | --- |
|  |  | **Have any disciplinary actions been initiated or are any pending against you by any state licensure board?** |
|  |  | **Has your license to practice in any state ever been denied, limited, reduced, lost, suspended, revoked or relinquished (voluntarily or involuntarily?** |
|  |  | **Have you ever been sanctioned, lost, barred, excluded, investigated, suspended or otherwise restricted from participating in any private, federal or state health insurance programs (example: Medicare/Medicaid)?** |
|  |  | **Have you ever been the subject of an investigation by any private, federal or state agency concerning your participation in any private, federal or state health insurance program?** |
|  |  | **Has your Federal DEA certificate or any State Controlled Substance Certificates, including Idaho be voluntarily or involuntarily suspended, denied, limited, reduced, lost, relinquished or revoked?** |
|  |  | **Is your Federal DEA or any State Controlled Substance Certificate, including Idaho currently being challenged?** |
|  |  | **Have you ever, at any time, been charged and arrested for a felony?** |
|  |  | **Have you ever been denied membership in a managed care plan?** |
|  |  | **Has any information been submitted, or currently in process of being submitted, on you to the National Practitioner Data Bank?** |

**EDUCATIONAL DATA**

**College/University Degree Date of Graduation**

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |

**Internship/Residency/Fellowships:**

**Location Type Dates of Affiliation**

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |

**License Number**

**NPI Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Drug Enforcement Agency Administration # \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Expires\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ISB Pharmacy Registration Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**All information submitted by me to The Marie Blanchard Friendship Clinic, INC, is true to my best knowledge and belief. I hereby agree to provide quality of care within the scope of my practice and demonstrate professional integrity while serving those individuals with no medical or healthcare coverage.**

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

**Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Additional Information need for our Mal-Practice Insurance through the Federal Tort Claims Act:** [**https://bphc.hrsa.gov**](https://bphc.hrsa.gov) **Under Free Clinics**

**1. Identification (government issued picture ID)**

**2. Current life support training (if you have it)**

**3. Rubella, Rubeola, Varicella, and Hepatitis B antibody titers; TB skin or blood test results, and proof of Tdap immunization**

**4. Complete Annual Malpractice form**

**2019 Provider Application**