THE WAY CLINIC VOLUNTEER APPLICATION Date_____

Name (Last) (First) (Middle)

Mailing Address City State Zip

Work Telephone / Home Telephone / Cell Phone

Email: _____ _____
Emergency Contact Telephone Number

How did you hear about this volunteer opportunity? _____

Education _____ Birth Date _____

List any professional license, registration, or certificate you currently possess (include certificate/license number):

_____

List your most recent employment experience:

Employer Mailing Address Phone

Job Title Dates of Employment

Check the area(s) in which you would like to volunteer?

___Front Desk ___Translator ___Nurse ___Physician/ARNP ___Triage

___Other:

Do you speak Spanish? _____ Any other languages? _____

How often do you want to volunteer? _____

Which day(s) of the week would you prefer to volunteer? _____

Specify the days and time frames you are available to volunteer: _____

_____

Nurse/Triage ONLY Have you had a Hepatitis B vaccination? _____ Tetanus? _____

Have you ever been convicted of or plead nolo contendere to a driving or criminal offense?

Yes _____ No _____ If "yes", please explain, including types of offenses and dates:
[Please note that answering "yes" will not necessarily disqualify you from volunteering]

VOLUNTEER HEALTH SERVICES

THE WAY FREE CLINIC GREEN COVE SPRINGS, FL

VOLUNTEER HEALTH CARE PROVIDER PROGRAM (VHCPP) APPLICATION for SOVEREIGN IMMUNITY CONTRACT

Provider's Full Name: _____
(Last) (First) (Middle)

Address: _____
(Street) (City) (State) (Zip)

Phone Number: (____) _____ E-mail Address: _____
(Include Area Code) (Optional)

Occupation: _____ Specialty: _____ FL License Number: _____

It is recommended by the Department of Health that individual providers, applying for a VHCPP contract for sovereign immunity protection, and who are affiliated with a Professional Association, (P.A.)/Group, also establish a Sovereign Immunity contract to protect the P.A/Group and its employees. Please indicate if you would like a contract for the P.A/Group you're affiliated with.

CHECK APPROPRIATE RESPONSE, SIGN AND DATE THE FORM

Yes_____ No_____ N/A_____ PA currently contracted
(If Yes, please complete the following information)

Signature: _____ ***Date:*** _____

P A/Group Corporation Name: _____

Printed Name of Corporate Officer/Director with Contract Authority: _____

Business Address: _____
(Street) (City) (State) (Zip)

Mailing Address (if different from above address): _____

Phone Number: (_____) _____-_____ **FEI or Document Number:** _____

IN ORDER TO PROTECT CLIENTS A ROUTINE CHECK OF THE FLORIDA MEDICAL LICENSE AND CORPORATION NAME WILL BE MADE THROUGH THE FLORIDA DEPT OF HEALTH MEDICAL QUALITY ASSURANCE AND/OR THE FLORIDA DIVISION OF CORPORATIONS

License/Corporation Verification (for DOH use only)

Individual
Current Florida Health Professional License? Yes_____ No_____
License Status "Clear and Active? Yes_____ No_____

Corporation:
Active and Registered Florida Corporation? Yes_____ No_____

Verification Completed By: _____ _____
(Signature of VHCPP Regional Coordinator) Date

This completed application can be returned by fax to 904-417-7168, or mail to Lori Thompson, Department of Health, 1955 US 1 South, Suite 100, St. Augustine, FL 32086, or emailed to Lorraine_Thompson2@doh.state.fl.us
Be sure to indicate if you **do or do not** want a contract for your Professional Association.

VOLUNTEER HEALTH CARE PROVIDER PROGRAM

AGREEMENT BETWEEN THE HEALTH CARE PROVIDER AND THE DEPARTMENT OF HEALTH

THIS CONTRACT is entered into between the State of Florida, Department of Health, hereinafter referred to as the "department", and **CLIFFORD ANDREW BLUMENBERG, Medical Doctor,** hereinafter referred to as the "health care provider", for the purpose of improving access to health care for indigent residents by providing governmental protection to health care providers who offer free, quality health care services to underserved populations of the state. This contract is to ensure that health care professionals who provide such services as agents of the state are provided sovereign immunity while acting within the scope of duties pursuant to this contract and the requirements of the applicable health care practitioner laws and administrative rules.

I. THE HEALTH CARE PROVIDER AGREES:

A. It is a health care provider or provider which includes a birth center licensed under chapter 383; an ambulatory surgical center licensed under chapter 395; a hospital licensed under chapter 395; a physician or physician assistant licensed under chapter 458; an osteopathic physician or osteopathic physician assistant licensed under chapter 459; a chiropractic physician licensed under chapter 460; a podiatric physician licensed under chapter 461; a registered nurse, nurse midwife, licensed practical nurse, or advanced registered nurse practitioner licensed or registered under part I of chapter 464 or a facility which employs nurses licensed or registered under part I of chapter 464 to supply all or part of the care delivered under section 766.1115; a midwife licensed under chapter 467; a health maintenance organization certificated under part I of chapter 641; a health care professional association and its employees or a corporate medical group and its employees; any other medical facility the primary purpose of which is to deliver human medical diagnostic services or which delivers non-surgical human medical treatment, and which includes an office maintained by a provider; a dentist or dental hygienist licensed under chapter 466; any other health care professional, practitioner, provider or facility under contract with a governmental contractor, including a student enrolled in an accredited program that prepares the student for licensure as any one of the professionals listed in this paragraph; a free clinic that delivers only medical diagnostic services or non-surgical medical treatment free of charge to all low-income recipients; or any nonprofit corporation qualified as exempt from federal income taxation under s. 501(a) of the Internal Revenue Code, and described in s. 501(c) of the Internal Revenue Code, which delivers health care services provided by licensed professionals listed above, any federally funded community health center, and any volunteer corporation or volunteer health care provider that delivers health care services.

B. To deliver high quality, volunteer, uncompensated health care services as described in this paragraph to low-income persons as defined in section 766.1115, Florida Statutes, and referred to the health care provider by the department or the department's agent. The health care services to be provided are: health and/or dental care services to eligible clients referred by the department or its trained agent.

C. To permit the department, its agents and employees, access to all records related to this contract, including the patient records of the low-income persons treated by the health care provider delivering services pursuant to this contract.

D. To report any adverse incidents, as defined in section 395.0197(5), Florida Statutes, and information on treatment outcomes to the department if such incidents and information pertain to a patient treated pursuant to the contract. Adverse incidents and treatment outcomes must be reported in writing, by certified United States mail, return receipt requested, to the **Administrator/ Health Officer, Florida Department of Health in Clay County** within 15 calendar days of occurrence. The health care provider shall comply with all applicable reporting requirements as required by chapter 395, Florida Statutes, and his or her professional licensure law.

E. The department or its specifically designated agent will make patient selection and initial referral exclusively. All referred patients will present the health care provider with a completed Patient Referral Form, DH 1032. A provider may reject a referred patient upon a clear showing the patient's required care is not within the area of expertise of the provider and the patient's health care cannot reasonably be met by the provider. The provider agrees not to reject a patient on the basis of race, creed, national origin, age, gender, or religion.

F. This contract does not apply to emergency medical care.

G. To be subject to supervision, regular inspection and monitoring by the department.

H. If the health care provider is a federally funded community health center, to post notice in a place conspicuous to all persons that the federally funded community health center is an agent of the department and that the exclusive remedy for injury or damage suffered as a result of any act or omission of the health care provider or any employee or agent thereof acting within the scope of duties pursuant to the contract is by commencement of an action pursuant to the provisions of section 768.28, Florida Statutes.

I. If the health care provider is acting as the department's specifically designated agent as authorized by chapter 110, Florida Statutes, for determination of patient eligibility and referral as authorized by section 766.1115(11), Florida Statutes, and 64I-2.002, Florida Administrative Code, it shall:

1. Not engage in activities, which would, if conducted under any federal health care program, constitute prohibited acts as outlined in 42 USCS § 1320a-7b.

2. Comply with department administrative code rules and instructions from department employees regarding determination and approval of patient eligibility and referral.

3. Require all employees and volunteers of the health care provider who will determine patient eligibility and referral to successfully complete training conducted by the department.

4. Maintain all records required in the administration of the patient eligibility and referral.

5. Allow the department access to records and employees and volunteers during business hours for purposes of review and oversight of the health care provider's acts in determining patient eligibility and referral.

J. To serve as an agent for purposes of section 768.28(9), Florida Statutes, for thirty (30) days from the determination of ineligibility of a patient in the program, to allow for treatment until the patient transitions to treatment by another health care provider.

II. THE DEPARTMENT AGREES:

A. To provide written notice to each patient, or the patient's legal representative, that the health care provider is an agent of the department and that the exclusive remedy for injury or damage suffered as a result of any act or omission of the health care provider or of any employee or agent thereof acting within the scope of duties pursuant to the contract is by commencement of an action pursuant to the provisions of section 768.28, Florida Statutes.

B. To submit any adverse incident reports to the Agency for Health Care Administration if an adverse incident involves a facility licensed by the Agency for Health Care Administration.

C. To not transfer any patients to the health care provider based on a violation of the antidumping provisions of the Omnibus Budget Reconciliation Act of 1989, the Omnibus Reconciliation Act of 1990, or chapter 395, Florida Statutes.

D. To provide an online listing of the health care provider, hours volunteered and number of patient visits provided.

Release Form for Media Recording

I, the undersigned, do hereby consent and agree that The Way Free Medical Clinic, Inc., its employees, or agents have the right to take photographs, videotape, or digital recordings of me and to use these in any and all media, now or hereafter known, and exclusively for the purpose of The Way Free Medical Clinic, Inc.. I further consent that my name and identity may be revealed therein or by descriptive text or commentary.

I do hereby release to The Way Free Medical Clinic, Inc., its agents, and employees all rights to exhibit this work in print and electronic form publicly or privately and to market and sell copies. I waive any rights, claims, or interest I may have to control the use of my identity or likeness in whatever media used.

I understand that there will be no financial or other remuneration for recording me, either for initial or subsequent transmission or playback.

I also understand that The Way Free Medical Clinic, Inc. is not responsible for any expense or liability incurred as a result of my participation in this recording, including medical expenses due to any sickness or injury incurred as a result.

I represent that I am at least 18 years of age, have read and understand the foregoing statement, and am competent to execute this agreement.

Name: _____ Date: _____

Address: _____

Phone: _____

Signature: _____

Witness for the undersigned: _____

The Way Free Medical Clinic
Volunteer Confidentiality Policy

Given the nature of our work, it is imperative that we maintain the confidence of patient information that we handle in the course or our work. The Way Free Medical Clinic prohibits the release of any patient information to anyone outside The Way Free Medical Clinic except in limited circumstances. Discussions or disclosures of protected health information within the organization should be limited to the minimum necessary that is needed information to perform the work we do.

I understand the services provided to patients at The Way Free Medical Clinic are private and confidential and that I am bound to protect the privacy rights of The Way Free Medical Clinic patients. I understand that protected information exists in many forms, such as electronic, oral, written, or photographic, and that all such forms of information are strictly confidential and protected by federal and state laws that prohibit its unauthorized use or disclosure.

If, at any time, I knowingly or inadvertently breach patient confidentiality policy or procedures, I agree to notify a clinic staff member immediately. By signing below, I acknowledge that I have read and understand the above policy and I agree to observe it.

Signature: _____ Date: _____

Printed Name: _____