

VOLUNTEER LICENSED HEALTH CARE PROFESSIONAL IMMUNITY ACT APPLICATION FORM

Name of Clinic: County: Street Address: City, State, Zipcode: Telephone: Fax:	
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This program **DOES** [] **DOES NOT** [] receive third party (medical insurance) reimbursement for medical services provided to patients/clients. **Provide a copy of the most recent financial report or auditor's statement as documentation.**

Volunteer health care professionals listing	Medical Specialty

(Provide an additional sheet if required)

Attach a copy of: the clinic's mission statement to provide free or low cost services; statement or signed agreement of volunteer status (not receiving financial or other compensation) of volunteer health care professionals delivering services; statement that all professional health care providers providing services in the clinic have a current professional license; and the clinic's policy for notifying patients that volunteer health care professionals rendering medical services are immune from civil suit.

Clinic Administrator

Date

For Office Use Only	
Date Received: _____ Date Approved [] Disapproved [] _____ Date <u>Approval</u> terminated: _____	
_____ Approval Signature	_____ Date