Volunteer Health Care Provider Program (VHCPP)

APPLICATION FOR A VOLUNTEER HEALTH CARE PROVIDER PROGRAM CONTRACT

CLINIC: WE CARE MANATEE

Provider Name: _____
(Please Print) (Last) (First) (Middle)

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

Phone Number: (_____) _____ e-mail:_____
(Area code) (Please Print)

Occupation: _____ Specialty: _____ FL License Number: _____

Individual providers applying for a VHCPP contract for sovereign immunity protection that are affiliated with a Professional Association (P.A.), the Florida Department of Health recommends a sovereign immunity contract be established to protect the P.A.

Please indicate if you would like a contract for the P.A. you're affiliated with.

Yes_____ No _____ Not affiliated_____

Signature: _____ **Date:** _____

Printed Name of Professional Association: _____

FEI or Document Number: _____

Printed Name and Title of Corporate Officer/Director with Contract Authority:

_____

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

Phone Number: (_____) _____

TO PROTECT CLIENTS, A ROUTINE CHECK OF THE CORPORATION NAME AND PROVIDER'S PROFESSIONAL LICENSE WILL BE MADE THROUGH THE FLORIDA DIVISION OF CORPORATIONS AND THE FLORIDA DOH DIVISION OF MEDICAL QUALITY ASSURANCE.

License/Corporation Verification (For DOH Use Only)

Individual
Current Florida Health Professional License? Yes _____ No _____
License Status "Clear and Active"? Yes _____ No _____

Corporation
Active Florida Professional Association? Yes _____ No _____ N/A _____

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