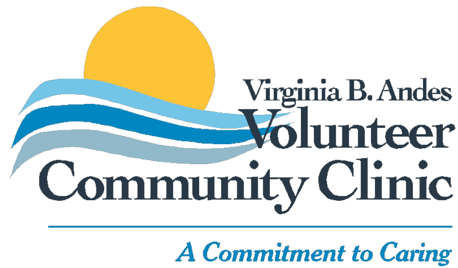


# Volunteer Application

Date: ____________________

Name: _______________________________________________________
Main Contact #_________________________ Alternate Contact # ________________________
Address: _____________________________________________________
_____________________________________________________________

Email Address: _______________________________________________
Birthday: ____________________________________________________

Reason for Becoming a Volunteer:
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

Applicant's Background (type of job held, skills in working with people, computer skills, etc.):_________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

Applicants Area of volunteer interest:

| | | |
|---|---|---|
| ___Medical Data Entry | ___ Pharmacist | ___Pharmacy Front Office Work |
| ___Clinic Front Office Work | ___ Nurse | ___Pharmacy Dispenser |
| ___Patient Advocate | ___Medical Provider | ___ Pharmacy Technician |

Volunteer is here year round_____ Volunteer is here only from ____ to_____
What days of the week would work best for you: Mon., Tues., Wed. Thurs. Friday
___Morning 9-1 pm, ___Afternoon 1-5 pm, ___Evening 5-8 pm
**We ask a minimum commitment of one four hour shift per week, (you may work more if you so desire)**

**Background checks are performed for all volunteers.**

**For internal office use only:**
Attempts to reach: _________________________________________________________
Other: ____________________________________________________________________
Date Background check was completed: ____________________________________

VBA7/20

Volunteer Health Care Provider Program (VHCPP)

**APPLICATION FOR A VOLUNTEER HEALTH CARE PROVIDER PROGRAM CONTRACT**

**CLINIC: Virginia B. Andes Volunteer Community Clinic**

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

**Return application form to**: Clinic Coordinator @___________________________
CLINIC NAME

VHCPP Regional Coordinator: Marielys Mujica Email: Mariely.MujicaPerez@flhealth.gov

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