

EDWARD R. LEAHY JR. CENTER
CLINIC FOR THE UNINSURED

A Partnership between The University of Scranton And
the Lackawanna County Medical Society

VOLUNTEER HEALTH CARE PROFESSIONALS INITIAL INFORMATION

A. Personal Data

Name:

Mailing address, home (REQUIURED):

Date of Birth:---/---/-----

Home phone # () _____ Mobile # () _____
Fax # _____

Email address _____

(E-mail is the preferred source of communication with the Leahy Clinic)

Are you currently in practice? Yes No

If No, please explain why_____.

B. Educational/Training History
Education (Please begin with the most recent)

Institution/location	Degree	Dates attended
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Institution/location	Degree	Dates attended
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Institution/location	Degree	Dates attended
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C. Volunteer Interest

- I would like to volunteer at the Leahy Center Clinic on Thursdays
 - Weekly
 - Monthly
 - Ever other week
 - Other _____

- I would like to volunteer at the Leahy Center Clinic on Thursdays from:
 - 2pm to 4:30pm
 - 4pm to 7pm
 - 2pm to 7pm
 - Other _____

D. Professional Data

Pennsylvania License # and expiration date: _____

Board Certified? Yes No

Name of Board and date: _____

Teaching positions (past, present), if any:

E. Other Information

1. **Have you ever been convicted of a misdemeanor or felony?** Yes No
2. **Are you aware of any circumstances which may affect or are likely to affect your ability to perform your professional duties?** Yes No
3. **Have your privileges at any hospital been denied, suspended or revoked or not renewed, or is any such action pending?** Yes No
4. **Have you been censured by any hospital, county/state, medical society, or is any such action pending?**
 Yes No
5. **Has your malpractice insurance ever been denied or cancelled?** Yes No
6. **Are there any restrictions on your state license, in the past or present, or is any such action pending?** Yes No
7. **Have you been involved in any professional claims, suits, settlements or judgments, or are any such actions pending?** Yes No

If the answer to any of these 7 questions is YES, explain below or attach additional pages.

Allegations:

Specialty Involved:

Action taken:

Final outcome:

Malpractice/professional liability coverage
Do you currently carry malpractice insurance?
If yes, please complete the below

Yes **No**

Name of company

Policy number _____

Contact person & phone _____

Amount _____

Expiration Date _____

Along with this application include the following as REQUIRED for the deeming process for the Federal Tort Claims Act (FTCA) coverage:

- Social Security number _____
- Copy of Current State License
- Copy of a government issued picture ID (PA drivers or passport)
- Health fitness statement attesting to your ability to perform requested privileges
- Immunization and TB screening status (this may be included in health fitness statement)
- Copy of current CPR training
- Copy of the PA State Police Clearance and PA Child Abuse Clearance
- Copy of a current malpractice insurance

Volunteer Physician Agreement: Release of Information

1. Professional liability insurance: I authorize and consent for the Leahy Center Clinic to obtain from my liability insurance carrier any and all information regarding insurance coverage, premiums, claims and suits against me as well as settlements or judgments made on my behalf.
2. I authorize and consent for the Leahy Center Clinic to do a query the National Provider Data Bank.

Signature (please do not type)

Date