



Dear Friend,

Thank you for your interest in volunteering with the Rutland County Free Clinic! Through the generosity of our volunteers, we are able to help many uninsured and underinsured adult members of our Rutland County communities meet their essential healthcare needs.

Please find enclosed our New Volunteer documents so you may officially apply as a volunteer Practitioner with Park Street Healthshare, Inc. dba Rutland Free Clinic.

Through the federal government, we are able to obtain free medical malpractice insurance for you. We maintain this insurance on all of our volunteer practitioners. In order to do so, we ask that you complete the application and return it with a copy of the forms listed below. Several of the items on the list may be on file with your current practice's Office Manager. The Statement of Personal Fitness and TB results can be completed by your medical provider and faxed or emailed to us.

- A copy of your current Vermont professional license
- A copy of your current CPR or ACLS certification (if any)
- A copy of your current driver's license or passport
- Your Statement of Personal Fitness including results of TB test and immunization status.
- A short narrative explaining any malpractice claims against you in the past 10 years.

If you have any questions as you process your application, please contact me directly at (802) 774-1085 or email [tiap@rutlandcountyfreeclinic.org](mailto:tiap@rutlandcountyfreeclinic.org). I look forward to receiving your application and assisting you in establishing a volunteer opportunity that you will cherish.

Peace and good health,



Tia M. Poalino  
Executive Director

Enclosures: Healthcare Provider Volunteer Application, Volunteer Healthcare Provider Statement of Personal Fitness.



**Healthcare Provider Volunteer Application**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Former name when attending school: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Email: \_\_\_\_\_

Are you currently in school? N Y If yes, when do you graduate? \_\_\_\_\_

Hours and days you are available to volunteer: \_\_\_\_\_

How often would you like to volunteer? \_\_\_\_\_

Can you provide healthcare in another language other than English? If so, which language?

How did you learn about the Rutland County Free Clinic? \_\_\_\_\_

The Clinic's malpractice insurance is provided by the Federal Government through the Federal Tort Claims Act; Free Clinics Insurance Program. In order for you to volunteer with the clinic, you must be credentialed and then deemed (approved) by the FTCA government program. This takes approximately 8 weeks and the following information is necessary to complete this process:

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

School of Graduation: \_\_\_\_\_ Year of graduation: \_\_\_\_\_

School Address: \_\_\_\_\_

License/Registry#: \_\_\_\_\_ State of Licensure: \_\_\_\_\_ Occupation: \_\_\_\_\_

DEA # \_\_\_\_\_ NPI # \_\_\_\_\_

Employer Name and Address: \_\_\_\_\_



**RUTLAND COUNTY  
FREE CLINIC**

*A path to good health.*

145 STATE STREET | RUTLAND, VT 05701

PH: 802-775-1360 | FAX: 802-774-5004

**Healthcare Provider Volunteer Application continued:**

Any additional licenses? N Y State: \_\_\_\_\_ Occupation: \_\_\_\_\_

Malpractice Insurance? N Y - Company: \_\_\_\_\_

Do you have any malpractice claims against you, past or pending? N Y - Please explain (attach additional sheets if necessary).

\_\_\_\_\_  
\_\_\_\_\_

CPR Certified? N Y

Please list the name, email and phone number of three (3) professional references, including at least two references who have worked with you in a medical capacity (please do not list relatives):

Name: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you ever been convicted of a crime? N Y – Please explain (attach additional sheet if necessary) \_\_\_\_\_

Your signature below indicates your permission to allow Park Street Healthshare, Inc., DBA Rutland County Free Clinic staff to contact the references listed above and that the information provided in this application is correct.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Opportunities for volunteers are provided without regard to religion, creed, race, national origin, age, sexual orientation, or gender.



**Volunteer Healthcare Provider Statement of Personal Fitness**

The Federal Tort Claims Act's Free Clinic Malpractice Insurance Program requires that each volunteer healthcare provider submit a statement from a licensed physician confirming their health, fitness, or ability to perform the requirements of the volunteer position, including TB test results and immunization status.

I have examined \_\_\_\_\_ and find he/she is able to perform the requirements of the volunteer position without difficulty.

TB test result: Quantiferon Gold test date: \_\_\_\_\_ Result: \_\_\_\_\_

Or, if having PPD skin testing, two tests are recommended, tests should be 1-3 weeks apart.

PPD #1 date \_\_\_\_\_ Result: \_\_\_\_\_ PPD #2 date: \_\_\_\_\_ Result: \_\_\_\_\_

Comments:

Printed name of licensed physician: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_