PRINT NAME _____

For Office Use Only_____

_____

_____

Position _____

VW NP AO A I

KC CARE Clinic

The purpose of the Kansas City CARE Clinic is to promote health and wellness by providing quality services to those challenged with access to basic care.

VOLUNTEER PHYSICIAN'S APPLICATION

Volunteers are the foundation of the services we provide.

Midtown Location: 3515 Broadway, Kansas City, MO 64111
Prospect Location: 6400 Prospect, Ste 200, Kansas City, MO 64132
Volunteer Manager: (816) 753-5144, ext. 1261
www.kccareclinic.org

United Way

Getting to Know You

Date _____

Name_____ Address _____

City_____ State_____ Zip Code_____

Home Phone #_____ Cell Phone # _____

Office Phone #_____ Fax #_____

E-mail address_____ Date of Birth _____

Emergency Contact Name and Phone # _____

Are you:

- ☐ Currently in practice
- ☐ Retired (Date of retirement? _____)

If currently in practice:

Employer _____ Address _____

City_____ State_____ Zip Code_____

Please list the name, address and phone numbers for three physician references currently in practice in the metropolitan Kansas City area:

Name	**Address**	**Phone**

Why would you like to volunteer your time and talent at the Clinic? _____

_____

_____

Professionally Speaking

Medical Education

_____

School Degree Year

Residency/Fellowship

_____

School Degree Year

Credentials

Please include copies of the following credentials with your application.

1. Attach your **CV/Resume**, if available.
2. **Missouri Medical Licensure Number** _____ Exp. Date _____
3. Proof of Malpractice Insurance Company name _____

   Amount_____ Exp. Date _____ Policy number _____
4. Name and phone number of an area hospital where you have active staff privileges.

   _____

   Hospital Phone number
5. UPIN# or NPI#, if available: UPIN_____ NPI_____

Please answer the following questions:

1. Have your privileges at any hospital been denied, suspended, revoked or not renewed, or is there any action pending in that case? ☐ Yes ☐ No
2. Have you been involved in any liability action, or is there action pending in such case? ☐ Yes ☐ No
3. Have you been charged or convicted of a drug related misdemeanor or felony, or is there action pending in such case? ☐ Yes ☐ No
4. Have you been asked to make any reform or compromise in connection with the Drug Enforcement Administration, or is there action pending in such case? ☐ Yes ☐ No
5. Have you been censored by any hospital, county/state, medical societies, or is there action pending in such case? ☐ Yes ☐ No
6. Has there been any restriction in your state licensure, or is there action pending in such case? ☐ Yes ☐ No
7. Do you have a physical or emotional condition, including alcohol or drug dependence, which may affect or is likely to affect your ability to perform your professional duties? ☐ Yes ☐ No

** If any of the above questions is answered YES, please provide additional information in a separate letter.

For Staff Use Only: ☐ Confirmed privileges Date _____ Int. ___

Defining Your Commitment

Please check your preferences:

☐ 1 clinic per week ☐ 1 clinic every two weeks ☐ 1 clinic per month

☐ 1 clinic every other month ☐ pro-bono referrals

☐ mornings (9 - 12) ☐ afternoons (1 – 4) ☐ evenings (6 – 9)

**Please note that two hour blocks of time can be arranged if better suited to your schedule.*

Please check days preferred:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

When are you available to start? _____

Comments regarding your schedule or availability _____

_____

Which Clinic location would you prefer to be placed?

☐ Midtown ☐ Prospect ☐ Both ☐ Either ☐ Unsure

Please provide us with the following information regarding your clinic preferences

Clinic Name:
☐ Family Medicine ☐ Adult Medicine ☐ Woman's Health/Gynecology
☐ Other Specialty_____

Schedule: Based on your experience, how many patients do you estimate that can you see in a 3-hour clinic session? _____
How frequently do you normally see patients (every 10 minutes, every 15 minutes, etc.)?
_____

Other information or Requests for your clinic sessions: _____

_____

_____

If you are accepted as a volunteer, would you also like to be placed on the on-call/substitution list?
☐ Yes ☐ No

RECOGNITION

From time to time we perform public relations efforts to recognize our Volunteer Physicians. The following information is utilized for that purpose.

Please list the Hospitals where you have privileges, their address and your status.

Hospital	Address	Status

Please list the local Medical Societies in which you are a member.

_____ _____

_____ _____

Please list the local newspapers that you read.

_____ _____

_____ _____

ACCEPTANCE OF APPOINTMENT

I hereby accept appointment to the volunteer medical staff of Kansas City CARE Clinic. I agree to abide by the rules and regulations of the Administration, Health Care Advisory Committee, medical staff, as well as any amendments added thereto.

I fully understand that any significant mis-statements in or omissions from this application constitute cause for denial of appointment or cause for summary dismissal from the medical staff. All information submitted by me in this application is true to the best of my knowledge and beliefs.

_____ _____

Signature of Applicant Date

Please mail your completed application, a copy of your license, proof of malpractice insurance and your signed Kansas City CARE Clinic Scope of Practice to:

Kansas City CARE Clinic
3515 Broadway
Kansas City, MO 64111
Attention: Volunteer Manager

THANK YOU!