

IMPORTANT - READ PRIOR TO COMPLETING APPLICATION/ PROTECTION AGREEMENT

The Individual Volunteer Health Care Provider application/protection agreement form **requires two signatures upon submission**. Signatures are required in "Section 5 Authorization for Release of Personal Information" and in "Section 19 Signature of Agreement."

Until this document has been signed by the DEPARTMENT, it is NOT a valid protection agreement. If approved by the DEPARTMENT, a signed copy will be returned to you.

SECTION 1. GENERAL

Name. Enter your first and last names.

Address. Enter the mailing address for correspondence with the Volunteer Health Care Provider Program.

Phone (daytime number). Enter area code and phone number.

Cell Phone Number. Enter area code and phone number, if available.

Email. Enter email address, if available. By providing us with your email address, you agree we may communicate with you by electronic mail. The VHCPP prefers to communicate with participants by electronic mail.

License. Enter the current license, certification, or registration number for your profession.

Specialty. Mark yes if being referred by the **Specialty Care Referral Network**.

Identify your Profession. Check the box identifying your profession.

Self-Query report required. Professions with a red astericks (**) **must submit the self-query report obtained from the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank with the completed Individual Volunteer Health Care Provider application/protection agreement.**

o Access the data bank web site at www.npdb-hipdb.hrsa.gov, select the "How to Get Started" link under the **Practitioners Section** and follow the online instructions to complete your Self-Query.

o All self-query requests are assessed a \$8.00 fee for the Data Bank. Complete instructions for performing a self query are on the data bank web site.

o If you do not have access to the internet call the data bank customer service center for assistance at 1-800-767- 6732.

o Upon receipt of the completed self query report, make a copy for your file and submit the original report with the Individual Volunteer Health Care Provider application/protection agreement to: Lloyd Burnside, Volunteer Health Care Provider Program, Iowa Department of Public Health, Lucas State Office Building, 321 E. 12th Street, Des Moines, IA 50319.

SECTION 2. HOURS & SITE LOCATION

Hours. Enter the number of hours you may possibly provide health care services in a week. This number does not require you to work the number of hours specified for a week. You will be provided coverage under the Volunteer Health Care Provider Program for the hours specified but not beyond.

Site Location. Enter the name and address information for each site location where health care services will be provided.

SECTION 3. PERSONAL HISTORY

Personal History. In answering each of the questions, select the appropriate box next to each question. **For each "YES" answer**, a separate, signed statement giving full details, including date(s), location(s), action(s), organization(s) or parties involved and specific reason(s) **must** be included with the application/protection agreement. Read the definitions listed below before completing the personal history questions.

"Ability to practice within your profession with reasonable skill and safety" means ALL of the following:

- o cognitive capacity,
- o ability to communicate with patients and other health care providers,
- o capability to perform health care services within your profession.

“Medical condition” means any physiological, mental, or psychological condition, impairment, or disorder, including drug addiction and alcoholism.

“Chemical substances” means alcohol, legal and illegal drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber’s direction, as well as those used illegally.

“Currently” does not mean on the day of, or even in weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of chemical substances or medical conditions may have an ongoing impact on the ability to function and practice, or has adversely affected the ability to function and practice within the past two (2) years.

“Improper use of drugs or other chemical substances” means **ANY** of the following:

- o The use of any controlled drug, legend drug, or other chemical substance for any purpose other than as directed by a licensed health care practitioner.
- o The use of any substance, including but not limited to, petroleum products, adhesive products, nitrous oxide, and other chemical substances for mood enhancement.

“Illegal use of drugs or other chemical substances” means the manufacture, possession, distribution, or use of any drug or chemical substance prohibited by law.

SECTION 4. PROFESSION, PATIENT GROUPS, AND HEALTH CARE SERVICES

Profession. Complete the section applicable to your profession.

→**NOTE:** For all Physician Assistants a supervising physician must sign the application/protection agreement signifying they have agreed to act as supervising physician for the PA.

Patient groups. Each profession has up to four patient groups which may be served. For each service checked you must identify which patients groups will be served.

Services. Check the health care services you will be providing for Volunteer Health Care Provider Program (VHCPP).

SECTION 5. AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION

Signature. Signature of applicant is **required**. Applicants will be contacted to resubmit appropriate page not properly signed.

Date. Enter date the application is signed.

SECTION 6-SECTION 19. PROTECTION AGREEMENT

These sections contain the INDIVIDUAL VOLUNTEER HEALTH CARE PROVIDER protection agreement.

Signature. Signature of applicant is **required**. The INDIVIDUAL VOLUNTEER HEALTH CARE PROVIDER is not protected for volunteer services provided prior to the signing of the protection agreement by the DEPARTMENT. Once fully executed, this document serves as the protection agreement between the INDIVIDUAL VOLUNTEER HEALTH CARE PROVIDER and the DEPARTMENT. The protection agreement shall be effective for two years from the date of execution. (Date of DEPARTMENT signature on the last page of the agreement.) A fully signed copy will be sent to the INDIVIDUAL VOLUNTEER HEALTH CARE PROVIDER.