



COASTAL MEDICAL ACCESS PROJECT
PO Box 1357 - Brunswick GA 31521

Application for Volunteer Licensed Health Care Providers

(Download form, complete and email as an attachment to jgriffis@cmapga.org.)

NAME

Birthdate

Home Address

Business Address

Home Phone

( ) -

Business Phone

( ) -

Home Email

Business Email

EMERGENCY NOTIFICATION

(Person to contact in case of emergency or illness.)

Name

Relationship

Phone #1

( ) -

Phone #2

( ) -

Street Address

City

Check appropriate title & status. List specialty, if applicable, & enter license or DEA number with date of expiration.

TITLE

- Physician Dentist PA NP RN LPN RDH Pharmacist Other

SPECIALTY:

STATUS: Active practice Retired

LICENSE NUMBER:

Active Inactive Expiration Date:

DEA NUMBER:

Expiration Date:

PHYSICIAN ASSISTANT'S / NURSE PRACTITIONER'S SPONSOR:

VOLUNTEER SERVICE AVAILABILITY: (Please complete this section.)

I can serve: hours time(s) per week time(s) per month time(s) every other month

I prefer to be scheduled:

- morning afternoon evening

Other/Consultation

The day(s) I prefer:

REFERRAL PATIENTS:

I will see referral patients in my private office free of charge will set up a payment plan

I prefer to see the following number of patients per week per month every other month.

I prefer to only take patients on a case-by-case basis.

Further explanation of specific skills, interests and/or preferences.

**IMMUNIZATIONS:**

**Hepatitis B:** Date of last vaccination \_\_\_\_\_  
**Tuberculosis:** Date of last test \_\_\_\_\_

**LICENSING:**

**Physicians, Dentists, and Chiropractors** must possess a valid medical license in any jurisdiction in the US as required for his/her discipline or specialty. *For those with an out-of-state license, the Georgia Volunteer Health Care Program will guide you toward acquiring a Special Georgia Medical License, or you may call 404-656-3913 or go online to <http://www.medicalboard.state.ga.us> for more information about the Volunteer in Medicine Act Special License.*

**Nurses, Nurse Practitioners, Physician Assistants and all other licensed health care professionals** must possess a valid license in the state of Georgia as required for his/her discipline or specialty.

**MALPRACTICE INSURANCE COVERAGE:**

**All Volunteer Health Care Providers** must possess malpractice insurance either **FREE** from the Georgia Volunteer Health Care Program, OR provide proof of private malpractice insurance. ***Georgia’s Volunteers in Medicine Act provides a full range of malpractice coverage for licensed volunteer providers including sovereign immunity for those approved by the program. Providers waiving their right to sovereign immunity protection from the state will be required to provide CMAP with proof of malpractice coverage.***

**CREDENTIALING:**

**All Volunteer Health Care Providers** must be credentialed by the Georgia Volunteer Health Care Program, OR be a member in good standing on the medical staff of the Southeast Georgia Health System.  
Please check all that apply:

- I am a member in good standing on the medical staff of the Southeast Georgia Health System.
- I am applying for Sovereign Immunity through the Georgia Volunteer Health Care Program.

**SIGNATURE:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**CONFIDENTIALITY AGREEMENT**

I, \_\_\_\_\_, understand that in the course of my work with the Coastal Medical Access Program (CMAP), I may learn certain facts about individuals being served by CMAP that are of a highly personal and confidential nature including medical conditions and treatments, finances and living arrangements and relationships with family and others. Additionally, I may learn certain business information such as financial and marketing data, budget information, bid proposals and research and development ideas. I understand that such information must be treated as completely confidential and that any breach of confidentiality concerning clients or business matters may result in my dismissal from CMAP as well as possible prosecution to the fullest extent of the law, where applicable. I also understand that similar information learned about CMAP volunteers or staff is to be treated as confidential. Except to those individuals within CMAP with a valid need to know, I agree not to disclose patient information of a personal and confidential nature without consulting my supervisor and assuring that the patient has signed a release of information form, where applicable.

**Name:** (Please Print) \_\_\_\_\_

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

**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_