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**Volunteer Health Care Provider Program (VHCPP)**

**APPLICATION FOR A VOLUNTEER HEALTH CARE PROVIDER PROGRAM CONTRACT**

**We Care of Lake County**

Provider Name:

(Please Print) LAST FIRST MIDDLE

Address:

(Please Print) (Street) (City) (State) (Zip)

Phone Number: ( ) E-Mail:

(Area code) (Please Print)

Occupation: FL License Number:

***Individual providers applying for a VHCPP contract for sovereign immunity protection that are affiliated with a Professional Association (P.A.), the Florida Department of Health recommends a sovereign immunity contract be established to protect the P.A.***

**Please indicate if you would like a contract for your affiliated Professional Association.**

### Yes\_\_\_\_\_\_ No \_\_\_\_\_\_\_ Not Affiliated\_\_\_\_\_\_\_\_\_ (Mark One)

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

***Printed Name of Professional Association:***

***FEI or Document Number:***

***Printed Name and Title of Corporate Officer/Director with Contract Authority:***

**Business Address**:

(Street) (City) (State) (Zip)

**Phone Number**: ( )

TO PROTECT CLIENTS, A ROUTINE CHECK OF THE CORPORATION NAME AND PROVIDER’S PROFESSIONAL LICENSE WILL BE MADE THROUGH THE FLORIDA DIVISION OF CORPORATIONS AND THE FLORIDA DOH DIVISION OF MEDICAL QUALITY ASSURANCE.

**License/Corporation Verification (For DOH Use Only)**

Individual

Current Florida Health Professional License? Yes No

License Status “Clear and Active”? Yes No

Corporation

Active Florida Professional Association? Yes No N/A

Verification Completed By:

Signature of VHCPP Regional Coordinator Date

**Return application form to**: Joyce Coufal, Regional Volunteer Coordinator, Volunteer Health Services,

P. O. Box 1305, Tavares, FL 32778 or scan to: [Joyce.Coufal@flhealth.gov](mailto:Joyce.Coufal@flhealth.gov): rev. 7/15