1606 - $50.00

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243
(800) 778-4123, ext. 5324384
www.tennessee.gov

APPLICATION FOR REGISTRATION TO PROVIDE VOLUNTEER HEALTH CARE SERVICES

Use of this application requires the sponsoring organization to file a quarterly voluntary services report with the department during the current quarter that lists all licensed health care providers who provided voluntary health care services during the preceding quarter. The sponsoring organization shall maintain additional information, including the date, place and type of services provided, on file for five (5) years following the date of service. The report is to be forwarded to: Department of Health, Board of Medical Examiners, Volunteer Health Services Coordinator, 665 Mainstream Drive, Nashville, TN 37243.

Please submit the completed application along with a check or money order in the amount of fifty dollars ($50.00) payable to the Tennessee Department of Health to the following address:

Tennessee Department of Health, Board of Medical Examiners
Attention: Volunteer Health Services Coordinator
665 Mainstream Drive
Nashville, Tennessee 37243

Name of Sponsoring organization: _____

Name of officials responsible for the operation of the sponsoring organization:

_____

_____

Address of the sponsoring organization's principal office:

Street

City County State Zip Code

Telephone

Address of official(s) responsible for the operation of the sponsoring organization if different from above: (Please attach additional sheets if necessary in order to provide this information).

Street

City County State Zip Code

Telephone

Brief description of volunteer services to be provided: (Please attach additional sheets if necessary in order to provide this information):

Signature of Authorized Officer Date

CERTIFICATION

I, the undersigned, as the authorized officer of the _____
(Name of Volunteer Health Services Organization)

hereby certify compliance by this organization with each of the following:

1. That there will be no charges or any kind to patients or to any third party on behalf of the patients for any services provided to them by health care providers under the auspices of this organization.
2. That all health care providers who are, or will be rendering services under the auspices of this organization are:
   a. licensed/certified in any state, territory, district or possession of the United States, as evidenced by copies of current licenses/certificates on file with this organization; or
   b. lawfully practicing pursuant to an exception/exemption from licensure/certification in any state, territory, district or possession of the United States and does not now and will not in the future regularly provide services under the Volunteer Health Care Services Act in Tennessee pursuant to that exception. "Regularly" means practice of more than sixty days within a ninety day period; and
   c. practicing with licenses/certifications that are not suspended or revoked pursuant to disciplinary proceedings in any jurisdiction, as evidenced by a copy of the health care provider's current license or certificate, or in the event that the health care provider is currently licensed in the state of Tennessee, a copy of the health care provider's license verification obtained from a state-sponsored website; and
   d. aware that any practice beyond the scope of an individual provider's profession will disqualify such provider from the protection of the "Volunteer Health Care Services Act" and subject such provider to possible civil and criminal liability; and
   e. aware that the intent of the "Volunteer Health Care Services Act" is to make their services available to Tennesseans who may otherwise not be able to obtain such services and not for the personal or professional gain of the provider and not to establish or promote the private practice of any providers in Tennessee.
3. All services provided under the auspices of this organization shall at all times be provided in compliance with all provisions of the "Volunteer Health Care Services Act."

_____ _____
Signature of Authorized Officer Date

_____ _____
Please Print Name of Authorized Officer Title of Authorized Officer

Sworn and subscribed before me, this the _____ day of _____, _____

_____
Notary Public SEAL

My Commission Expires: _____.