

Volunteer Health Care Provider Program

Application for a Charitable Health Care Provider Contract

Please print or type the information necessary to complete this application, including any attachments.

Name of Provider¹: _____

Address: _____

City/State: _____ Zip Code: _____ Phone: _____

Social Security Number : _____

Please list the Oklahoma Agency that issued your license or authorization to provide health care services that is relevant to your application to enter into a contract with a contracting agency to be a charitable health care provider:

License or certification number(s): _____ Date(s) of expiration: _____

Please attach a summary of any professional discipline assessed against you as a health care provider in the last five years, if any, including what the specific discipline was and what the underlying basis was for such discipline. Please check here , if not applicable.

I authorize the Oklahoma agency that issued my professional license or other authorization to provide health care services in Oklahoma to inform the contracting agency², upon its inquiry, of the status of my license or authorization, including whether my license is in good standing, for the purpose of processing this application.

(Signature of applicant)

Please identify your professional malpractice insurance carrier for the last five years:

Have you had any professional malpractice claims brought against you within the last five years?
 Yes No

If yes, please provide your claims history for any claim(s) brought against you within the last five years by attaching the claims information to this application. Minimally, the claims history must include the contact information of the reporting entity, the number of claims, a brief description of

each claim, the type of health care services being provided that precipitated each claim, and the money that was paid, or is being paid, per claim, if any.

I authorize my professional malpractice insurance carrier to inform the contracting agency or the Risk Management Division of the Department of Central Services, upon its inquiry, regarding any claims history for the last five years for the purpose of processing this application.

(Signature of applicant)

Please provide the following information:

List all free clinic(s) that you are providing services to include Name, Location, and Days and Hours you are scheduled.

Please check the following, which best describes your participation with a free clinic.

I provide my services at a free clinic(s) only.

I provide free specialty care to patients referred from a free clinic provider and declare that no charges or expected payment is required from the patient.

I hereby certify that the information provided in this application, including any attachments, is true and accurate to the best of my knowledge.

Applicant Signature: _____ Date: _____

Please return this application to: For questions or comments please Call:

Volunteer Health Care Provider Program (403) 271-8428 or E-mail Primary Care@health.ok.gov

Oklahoma State Department of Health Community Development Service, Rm 508.2 1000 N.E. 10th Street Oklahoma City, OK 73117

License and Credentials Verification (for department use only)
Verification completed by/date:
