

**THOUSAND SMILES FOUNDATION  
Volunteer Application**

**Medical \_\_\_\_\_  
Allied Health \_\_\_\_\_**

<b>INSTRUCTIONS</b>		
Copies of the following documents <i>must be submitted</i> with this application.		
<ul style="list-style-type: none"> <li>• A Copy of Your Current Professional License</li> <li>• Any Additional Licensure, Certifications, or Registrations Required by Your Clinical Service</li> <li>• Proof of Professional Liability Insurance Coverage</li> <li>• Curriculum Vitae/Resume</li> <li>• Recent Photo (for ID purposes only)</li> <li>• Copy of your Passport</li> </ul>		

<b>IDENTIFYING INFORMATION</b>		
Last Name:	First Name:	Middle Name:
Any other name under which you have been known? Name(s):		
Home Address:	City:	
	State:	Zip:
Home Telephone Number: ( )	Home Fax Number: ( )	
Pager Number: ( )		
Birth Date:	Citizenship:	
Social Security Number:	Male <input type="checkbox"/>	Female <input type="checkbox"/>

<b>PRACTICE INFORMATION</b>		
Physician or Allied Health Practitioner affiliated with (if applicable):		
Office Address:	City:	
	State:	Zip:
Telephone Number: ( )	Fax Number: ( )	

<b>EMPLOYMENT HISTORY</b>		
Employment Dates	From:	to:
Name of Employer:		
Address:	City:	
	State:	Zip:
Telephone Number:		
Type of Employment:		
Reason for Leaving:		

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Name of Employer:		
Address:	City:	
	State:	Zip:
Telephone Number:		
Type of Employment:		
Reason for Leaving:		

**EMPLOYMENT HISTORY CONTINUED**

Employment Dates	From:	to:	
Name of Employer:			
Address:	City:		
	State:	Zip:	
Telephone Number:			
Type of Employment:			
Reason for Leaving:			

*\*If additional space is required, attach additional sheets and reference the section being answered.*

**CURRENT/PREVIOUS AFFILIATIONS**

Name, City, and State of Facility:	Department:		
Status	Dates of Service:		

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Status	Dates of Service:		

Name, City, and State of Facility:	Department:		
Status	Dates of Service:		

*\*If additional space is required, attach additional sheets and reference the section being answered.*

**EDUCATION AND TRAINING**

Name of Institution:			
Address:	City:		
	State:	Zip:	
Course of Study:	Degree Earned:		
Years of Attendance	From:	To:	

Name of Institution:			
Address:	City:		
	State:	Zip:	
Course of Study:	Degree Earned:		
Years of Attendance	From:	To:	

Name of Institution:			
Address:	City:		
	State:	Zip:	
Course of Study:	Degree Earned:		
Years of Attendance	From:	To:	

**PROFESSIONAL LIABILITY (Current)**

Insurance Carrier:	Policy Number		
Policy Holder: ( ) Applicant			
Mailing Address:	City:	State:	Zip:
Per claim amount: \$	Aggregate amount: \$	Expiration Date:	

<b>PROFESSIONAL REGISTRATION LICENSURE, CERTIFICATIONS, ETC. (Past and Present)</b>			
Type		State:	
Number:	Year Issued:	Expiration Date:	
Status (Active, Restrictions, etc.)			

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Number:	Year Issued:	Expiration Date:	
Status (Active, Restrictions, etc.)			

<b>PROFESSIONAL REFERENCES</b>			
<b>LIST TWO PROFESSIONAL REFERENCES, PREFERABLY PHYSICIANS OR ALLIED HEALTH PRACTITIONERS WHO ARE FAMILIAR WITH YOUR WORK. IF POSSIBLE, INCLUDE AT LEAST ONE MEMBER FROM THE MEDICAL STAFF OF EACH FACILITY AT WHICH YOU HAVE PRIVILEGES.</b>			
Name of Reference:		Title:	Telephone Number:
Address:		City:	
		State:	Zip:
Name of Reference:		Title:	Telephone Number:
Address:		City:	
		State:	Zip:

<b>ATTESTATION QUESTIONS</b>	
<b>PLEASE ANSWER THE FOLLOWING QUESTIONS "YES" OR "NO." IF YOUR ANSWER TO ANY QUESTION IS "YES," PLEASE PROVIDE FULL DETAILS ON A SEPARATE SHEET.</b>	
1. Has your application for permission to perform medical services and functions at any hospital or other health care facility been denied?	
Yes:	No:
2. Has your permission to perform medical services and functions at any hospital or other health care facility been limited, suspended, revoked, not renewed, or subject to probationary conditions?	
Yes:	No:
3. Has your employment as a physician/allied health practitioner ever been terminated by your employer or has any contract pursuant to which you agreed to perform medical services been terminated by the other party to the contract?	
Yes:	No:
4. Has your license or certificate to practice your profession in any jurisdiction been limited, suspended, revoked, denied, or subjected to probationary conditions, or have proceedings toward any of those ends been instituted?	
Yes:	No:
5. Have you been denied membership or renewal or been subject to any disciplinary action in any professional society, local, state, or national?	
Yes:	No:
6. Have you voluntarily relinquished any permission granted to you to perform medical functions and services at a hospital or other health care facility?	
Yes:	No:

**ATTESTATION QUESTIONS CONTINUED**

7. Have you been denied professional liability insurance coverage or has your coverage been reduced, limited, or canceled?	
Yes:	No:
8. Have any professional liability lawsuits been filed against you?	
Yes:	No:
9. Have any professional liability judgments or settlements been made against you?	
Yes:	No:
10. Have you had any reports submitted to the National Practitioner Data Bank:	
Yes:	No:
11. Have you had or developed any mental or physical health problems that may affect your ability to practice your profession or the quality of your practice?	
Yes:	No:
12. Have you received any type of sanction or are you currently under investigation by a hospital, state licensing agency or other professional health care organization, or are there any pending or completed administrative, court, or other legal actions involving allegations against you of:  (I) Improper practices by Medicare, Medi-Cal, or another third party payor; or (II) Gross negligence or intentional wrongful acts related to the provision of patient care; or (III) Criminal violations (other than minor traffic violations)?	
Yes:	No:
13. Does your current Professional Liability Insurance extend to all privileges you have requested? If not, please list exclusions.	
Yes:	No:
14. Have you ever voluntarily relinquished clinical privileges, licensure, participation or employment in any health care organization?	
Yes:	No:
15. Have you ever voluntarily terminated or reduced your clinical privileges at another healthcare organization?	
Yes:	No:

**I FULLY UNDERSTAND THAT ANY SIGNIFICANT MISSTATEMENT IN OR OMISSIONS FROM THIS APPLICATION WILL CONSTITUTE CAUSE FOR DENIAL OF MY APPLICATION FOR AFFILIATION WITH THOUSAND SMILES FOUNDATION. I HEREBY AFFIRM THAT THE INFORMATION I HAVE FURNISHED TO THOUSAND SMILES FOUNDATION IN THIS APPLICATION AND IN ANY ACCOMPANYING DOCUMENT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.**

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**APPROVALS**

Clinical Service Chairperson:	Date:
Credentials Committee Chairperson:	Date:
Board of Directors:	Date:

**Send Your Completed Application To:**

**Thousand Smiles Foundation**

**Att: Mina Olimon**

**5261 Central Ave**

**Bonita, Ca 91902**