Volunteer Health Care Provider Program (VHCPP)

CONTRACT APPLICATION

WE CARE – INDIAN RIVER COUNTY

Provider Name: ____ Date: ____________
(Last) (First) (Middle)

Address: ____
(Street) (City) (State) (Zip)

Phone Number: (_________) ______________________ e-mail:______________________
(Area code)

Occupation: _____________ Specialty: ______________ 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 the P.A. you're affiliated with.

Yes______ No _______ Not Applicable __________ (P.A. currently contracted)

Name of Professional Association: ____

FEI or Document Number: ____

Name of Corporate Officer/Director with Contract Authority: _____________________________

Business Address: ____
(Street) (City) (State) (Zip)

Phone Number: (___________) _______________________

Signature:_____________________________________ Date:__________________

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

rev. 7/13 Please return to Steven.Krajewski@flhealth.gov