Providence
Medical Clinic of Kingsport

Medical Provider Application

The information provided on this application is classified as confidential and will be kept on file at Providence Medical Clinic. The information will be used to contact PMC providers regarding clinic operations and for verification of professional status. This information **will not** be released to sources outside Providence Medical Clinic.

Personal Information

Name: _____ Degree: _____

Date of Birth: _____

Social Security Number: _____

Home Address: _____

_____

Phone: _____ (cell)

_____ (home)

_____ (emergency contact)

Email Address: _____

(Email is the primary method used by PMC for contacting volunteers regarding scheduling and general clinic announcements. Please alert the clinical coordinator if you would like to receive communication by another method.)

Professional Information

Practice Name: _____

Practice Address: _____

Practice Phone: _____

Local Hospital Admitting Privileges: _____

Medical School: _____

(International medical graduates, please indicate
ECFMG Certificate Number_____Exp date_____

Post-graduate Training: 1) _____

Type of training_____

2) _____

Type of training_____

3) _____

Type of training_____

Name: _____

Licenses, Certifications

Professional License: Indicate all states you hold current or inactive license(s).

STATE	LICENSE NUMBER	EXPIRATION DATE

Please submit a copy of your current Tennessee license with this application.

Please provide DEA registration for each state in which you currently practice and prescribe medications.

STATE	DEA NUMBER	EXPIRATION DATE

BOARD CERTIFICATION/SPECIALTY

Names of specialty boards by which you are certified:

Name of Board: _____

Date Certified: _____Expiration Date: _____

Name of Board: _____

Date Certified: _____Expiration Date:_____

Reference

Please provide the name of a medical provider who we may contact for a peer reference regarding your professional competency and ethical character.

Reference Name: _____

Reference Email or Phone: _____

* In submitting this application to serve as a volunteer medical provider at Providence Medical Clinic of Kingsport, I agree to treat all patient information, medical and spiritual, as confidential. I also agree to support the clinic vision statement: *Providence Medical Clinic of Kingsport offering compassionate medical and spiritual care for the underserved residents of the Greater Kingsport area.*

Signed: _____Date:_____

Received by: _____Date:_____

05/22/2010

Providence
Medical Clinic of Kingsport
441 Clay St; Kingsport TN 37660
Phone: 423-247-4536 Fax: 423-247-5676

Confidentiality Agreement

All patient information at Providence Medical Clinic is considered confidential. This includes the patient's medical records and any information obtained through a spiritual support session with the patient.

As a paid staff member/volunteer at the Clinic, you are to regard with strictest confidence any information that you learn about a patient and his or her family. You cannot discuss any information that you have learned about a patient with his or her family without the patient's permission. You cannot discuss any information about a patient with other patients in the clinic, outside agencies, your family or personal acquaintances, only staff at Providence Medical Clinic as is necessary for the well-being of the patient.

HIPAA violations cannot be tolerated. Proper release of medical information may be accomplished by following set guidelines through written release of medical information. No information regarding PMCK patients may be discussed outside of clinic. All information is on a need to know basis. If information is not essential for you to do your job, do not access the information.

Providence Medical Clinic will discontinue the services of any volunteer who breeches this agreement.

**Please complete the agreement below:

I agree to keep all patient information at Providence Medical Clinic confidential and will not discuss any information about a patient outside of the Clinic.

Volunteer Name: (Please Print) _____

Volunteer Signature: _____ Date: _____

Witness Signature: _____ Date: _____