



Volunteer Health Care Provider Program (VHCPP)

CONTRACT APPLICATION

Program: \_\_\_\_\_

Provider Name: \_\_\_\_\_ Date: \_\_\_\_\_
(Last) (First) (Middle)

Address: \_\_\_\_\_
(Street) (City) (State) (Zip)

Phone Number: \_\_\_\_\_
(Area code)

Occupation: \_\_\_\_\_ Specialty: \_\_\_\_\_ FL License: \_\_\_\_\_

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: \_\_\_\_\_ Date: \_\_\_\_\_
Signature of VHCPP Regional Coordinator