MULTNOMAH COUNTY

HEALTH DEPARTMENT

Volunteer Health Care Provider Indemnification

VOLUNTEER HEALTH CARE PROVIDER APPLICATION

DEMOGRAPHICS:

Name in Full: _____

Workplace: _____ Work Phone: _____

Workplace Address: _____

City: _____ State: _____ Zip Code: _____

Work E-mail: _____

Home Address: _____ Home Phone: _____

City: _____ State: _____ Zip Code: _____

Home E-mail: _____

Where do you prefer to receive mail? ☐ home ☐ work

Where do you prefer to receive phone calls? ☐ home ☐ work

Where do you prefer to receive e-mails? ☐ home ☐ work

EDUCATION:

College/University: _____ Yr. Grad: _____ Degree: _____

Professional School: _____ Yr. Grad: _____ Degree: _____

Post Graduate Training: _____ Dates: ___

Foreign Language proficiency: Language _____

☐ Primary (native) language ☐ Beginner ☐ Intermediate ☐ Fluent (as a 2nd language) ☐ Non-Applicable

LICENSURE:

Board: _____ State: _____ Lic # _____ Issue Date: _____

DEA Registration: _____ I have not applied for my own DEA Registration Certificate.

___ I have applied for, but have not yet obtained, my own DEA Registration Certificate.

___ My DEA Registration # _____ Expiration Date: _____

___ Not Applicable/Other: _____

Board Certification ☐ Yes ☐ No Specialty _____ Expiration Date: _____

NPI #: _____

Are you currently credentialed through Multnomah County Health Department or CareOregon?

☐ **Yes** ☐ **No**

Enclose a copy of your license, DEA registration and Board Certificate(s). Return completed application to your recruiting clinic.

ATTESTATION QUESTIONS – This section to be completed by the Practitioner.
Modification to the wording or format of these Attestation Questions will invalidate the application.

Please answer the following question "yes" or "no". If your answer to any of the following questions is "yes", please provide details and reasons, as specified in each question, on a separate sheet. **Please sign and date each additional sheet.**

1.	Has your license, certification, or registration to practice your profession, Drug Enforcement Administration (DEA) registration, or narcotic registration/certification in any jurisdiction **ever been** denied, limited, suspended, revoked, not renewed, voluntarily or involuntarily relinquished, or subject to stipulated or probationary conditions, or have you **ever been** fined or received a letter of reprimand or is any such action pending or under review?	**YES ☐ NO ☐**
2.	Have you **ever been** suspended, fined, disciplined, or otherwise sanctioned, restricted or excluded for any reasons, by Medicare, Medicaid, or any public program or is any such action pending or under review?	**YES ☐ NO ☐**
3.	Have you **ever been** denied clinical privileges, membership, contractual participation or employment by any health care related organization*, or have clinical privileges, membership, participation or employment at any such organization **ever been** placed on probation, suspended, restricted, revoked, voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review?	**YES ☐ NO ☐**
4.	Have you **ever** surrendered clinical privileges, accepted restrictions on privileges, terminated contractual participation or employment, taken a leave of absence, committed to retraining, or resigned from any health care related organiztion* while under investigation or potential review?	**YES ☐ NO ☐**
5.	Has an application for clinical privileges, appointment, membership, employment or participation in any health care related organization* **ever been** withdrawn on your request prior to the organizations final action?	**YES ☐ NO ☐**
6.	Has your membership or fellowship in any local, county, state, regional, national, or international professional organization **ever been** revoked, denied, limited, voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review?	**YES ☐ NO ☐**
7.	Have you **ever** had board certification revoked?	**YES ☐ NO ☐**
8.	Have you **ever been** the subject of any reports to a state or federal data bank or state licensing or disciplinary entity?	**YES ☐ NO ☐**
9.	Have you **ever been** charged with a criminal violation (felony or misdemeanor)?	**YES ☐ NO ☐**
10.	Do you presently use any illegal drugs?	**YES ☐ NO ☐**
11.	Do you now have, or have you recently had, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or is reasonably likely to affect your current ability to practice, with or without reasonable accommodation, the privileges requested? If reasonable accommodation is required, please specify the accommodation(s) required on a separate sheet.	**YES ☐ NO ☐**
12.	Are you **unable** to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital appointment, with or without reasonable accommodation, according to accepted standards of professional performance?	**YES ☐ NO ☐**
13.	Have any professional liability claims or lawsuits **ever been** files against you? If yes, please complete **Attachment A** for **each** past or current claim and/or lawsuit.	**YES ☐ NO ☐**
14.	Has your professional liability insurance **ever been** terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you **ever been** denied professional liability insurance?	**YES ☐ NO ☐**

*** e.g. hospital, medical staff, medical group, independent proctice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other heatlh delivery entity or system**

I certify the information in this entire application is complete, current, correct, and not misleading. I understand and acknowledge that any misstatements in, or omissions from this application will constitute cause for denial of my application or summary dismissal or termination of my clinical privileges, membership or practitioner participation agreement. A photocopy of this application, including this attestation, the authorization and release and any or all attachments has the same force and effect as the original. I have reviewed this information on the most recent date indicated below and it continues to be true and complete. While this application is being processed, I agree to update the information originally provided in this application should there be any change in the information.

I agree to provide care for my patients, until the practitioner/patient relationship has been properly terminated by either party, or in accordance with contract provisions.

Signature: _____ **Date:** _____

OSHA TRAINING & IMMUNIZATIONS: **Volunteers are subject to OSHA regulations. OSHA requires yearly attendance at blood borne pathogens training, Hepatitis B vaccination, and an annual PPD test. Volunteers may receive these through their employer, or by contacting Multnomah County Health Department's Occupational Health Office (503-988-3406), which provides these services to Coalition volunteers free of charge. Volunteers must also be immune to measles, Rubella and chickenpox.**

I have read and understand the requirements on blood born pathogens, Hepatitis B vaccination, and PPD testing. I am currently in compliance, or will comply within 10 days of beginning my volunteer service.

_____ _____

Signature Date

COMMENTS / ADDITIONAL INFORMATION:

All information provided in this application is true to the best of my knowledge:

_____ _____

Signature Date

ATTACHMENT A

PROFESSIONAL LIABILITY ACTION DETAIL – *CONFIDENTIAL*

Please list any past or current professional liability claim or lawsuit, which has been filed against you in the past three (3) years. **Photocopy this page as needed and submit a separate page for EACH claim/event.** It is not acceptable to simply submit court documents in lieu of completing this document. Please complete each field. Please attach additional sheet(s), if necessary.

Practitioner's Name (print or type):

Month / Day / Year of the incident: and clinical details:

Your role and specific responsibilities in the incident:

Subsequent events, including patient's clinical outcome:

Month / Day/ Year the suit or claim was filed:

Name and address of insurance carrier/professional liability provider that handled the claim:

Your status in the legal action (primary defendant, co-defendant, other):

Current status of suit of other action:

Month / Day / Year of settlement, judgment, or dismissal:

If case was settled out-of-court, or with a judgment, settlement amount attributed to you:

I verify the information contained in this form is correct and complete to the best of my knowledge.

Signature:	Date:

ATTACHMENT B
LIABILITY PROTECTION PROVIDED BY MULTNOMAH COUNTY

This attachment summarizes
a) Multnomah County's approach to providing malpractice liability protection for licensed professionals who volunteer in Coalition clinics, and
b) Multnomah County's expectations of Coalition clinics and their volunteers.

THE OREGON TORT CLAIMS ACT

The Oregon Tort Claims Act (OTCA) in Oregon Revised Statutes 30.260 to 30.300 provides the legal framework for liability protection for Oregon's state and local governments. The OTCA is designed to protect governments and their employees. The OTCA basically does two things:

1) It limits the amount of damages a claimant can receive from the state or a local government for an injury or other harm arising out of the actions of the government or its employees and agents.
2) It requires the County to:
   a) provide a legal defense for employees against whom a claim of injury is made so long as the employee was acting within the course and scope of their assigned duties, and
   b) cover the costs of any payment made as a result of such a claim (whether due to settlement, or a judgment of a court). The County pays for these costs through a combination of self-insurance and excess insurance policies. So under the OTCA, it is the government who is responsible for paying the costs arising from a successful claim – not the employee.

BACKGROUND

More than 20 years ago, Multnomah County decided to extend liability protection to licensed health professionals who volunteer to provide patient care in clinics that are members of the Coalition of Community Health Clinics. The County did this in order to increase our community's capacity to provide health care for low-income and uninsured Multnomah County residents. The County judged that Coalition clinics were supporting the County's mission of providing medical care to specific populations in need. In effect, Coalition clinics were acting on behalf of the Health Department which is part of Multnomah County government.

The history of negligence claims against Coalition clinics and their volunteers has been extremely benign over the past 20 years. To the best of our knowledge, no claims have been filed, none of which have resulted in liability for either the County or individual voluntary health care professionals.

THE ROLE OF MULTNOMAH COUNTY

The County designates County-credentialed licensed health professionals who volunteered in Coalition clinics as "agents" of the county. Agents enjoy the same liability protections as county employees as outlined above. In a practical sense what this means is:

- If a claim is filed against a licensed health care professional as a result of their service as a volunteer in a Coalition clinic, the Office of the County Attorney will provide a legal defense for the volunteer.
- If there are financial damages as a result of a successful claim, the County will pay these damages.

LIMITATIONS TO LIABILTIY PROTECTIONS

It is critical to understand that there are limits to the County's ability to defend and indemnify Coalition clinic volunteers:

1) The County's liability protections apply only to claims made in State of Oregon courts. The County cannot assume liability for claims filed in federal courts (although federal courts are rarely the venue for healthcare malpractice claims).
2) The County's liability protections only apply to volunteers' actions that are consistent with the usual practice of health care within the community. Actions outside this usual scope and course will not be defended by the County, nor will damages be covered by the County. Examples of actions that would not be covered include:
   - health care practices that are outside of the usual scope of practice of a given licensed profession,
   - unprofessional or inappropriate social or sexual interactions with patients, and
   - any activities not directly related to patient care.
3) The County will attempt to position itself as the responsible party in case of a valid claim. However, the County cannot guarantee that it will be successful in focusing liability on itself; a claimant might succeed in making a claim and both against the County and an individual healthcare professional.

In December 2006, the Oregon Supreme Court ruled on a case known as *Clarke vs. OHSU*. The Multnomah County Attorney has reviewed the implications of this case, and is of the opinion that the liability protections offered by the County to Coalition clinic health care professional volunteers remains intact.

THE COUNTY'S EXPECTATIONS OF COALITION CLINIC VOLUNTEERS

The following represents the County's basic expectations and requirements of licensed healthcare professional volunteers who wish to

receive malpractice protection from Multnomah County.

1) You must be currently licensed as one of the types of health care professionals that the Health Department designates as eligible for coverage. This includes but is not limited to: MD/DO, Dentist, Nurse Practitioner, Naturopathic Physician, Chiropractor, Registered Nurse, Retired Physician, Physician Assistant, Podiatrist , Acupuncturist, Optometrist, Licensed Massage Therapist, Registered Dietitian, Licensed Clinical Social Worker, Licensed Psychologist, Certified Laboratory Technician, Licensed Physical Therapist, Occupational Therapist, Certified Medical Assistant or any licensed or certified health care professional approved by the Health Department Medical Director on a case by case basis
2) You must submit a Coalition of Community Health Clinics Credentialing Application, and that application must be approved by Multnomah County Health Department before you are covered. The County will not provide coverage to any licensed healthcare professional who is not credentialed by the Health Department.
3) You must report to the County and any Coalition clinics where you practice within three business days:
   a. Any restriction or limitation on your professional license that has been imposed since the time you are credentialed by Multnomah County Health Department.
   b. Any restriction or limitation on professional credentials or privileges you have received from any organization that performs health-care credentialing.
4) When serving in a Coalition clinic, you must practice within the usual scope of your profession as generally practiced in the community.
5) If you become aware of any claim or threat of a claim against you or a Coalition clinic in which you serve, you must report this within three business days to clinic supervisor or director.
6) If you become aware of any problems in patient care, or situations which you believe might lead to a claim, you must report the situation within seven business days the clinic supervisor or director.

As a volunteer of the Multnomah County Health Department, you are protected by the provisions of the Oregon Tort Claims Act. The County will defend, save harmless, and indemnify you from malpractice claims and liability arising from your volunteer placement as long as you limit the scope of your duties to assigned tasks and perform your work in good faith, in a manner that is not reckless or with intent to harm others **and report any claims arising from your volunteer work to the Multnomah County Health Department.** This protection is stated in the Oregon Tort Claims Act, ORS 30.260 - 300 and Administrative Guidelines HRS.05.05 and LEG.01.04.

Signature:_____ Date:_____

MULTNOMAH COUNTY
HEALTH DEPARTMENT

VOLUNTEER REFERENCE CHECK

Volunteer Health Care Provider Indemnification

Dear Volunteer:

Please:

1. **Fill out this first page, listing information on your reference(s);**
2. ***Sign and date*** **the release on the second page; and**
3. **Return all three of these pages, along with your completed application, copies of your license, board certificate(s) and DEA registration to the Volunteer Coordinator at the clinic that recruited you.**

Acceptable references: your current clinical supervisor - or if you have none - two colleagues who are familiar with your professional practice.

Current Clinical Supervisor: _____ Title: _____

FAX number: _____

Address: _____

Business Phone Number: _____

Or

1) Colleague: _____ Title: _____

FAX number: _____

Address: _____

Business Phone Number: _____

2) Colleague: _____ Title: _____

FAX number: _____

Address: _____

Business Phone Number: _____

MULTNOMAH COUNTY
HEALTH DEPARTMENT

VOLUNTEER REFERENCE FORM

Volunteer Health Care Provider Indemnification

TO: _____ FAX: _____

DATE: _____

FROM: AMIT SHAH, MD, MEDICAL DIRECTOR, MULTNOMAH COUNTY HEALTH DEPT.
KATE YEN, COORDINATOR

RE: REFERENCE REQUEST FOR _____ VOLUNTEER APPLICANT

THE PERSON NAMED ABOVE HAS APPLIED TO BE A VOLUNTEER HEALTH CARE PROVIDER. S/HE HAS ALSO SIGNED A RELEASE OF INFORMATION (SEE BELOW) SO THAT WE MAY RECEIVE REFERENCE INFORMATION FROM YOU. PLEASE TAKE A MOMENT TO COMPLETE THIS FORM AND FAX IT TO THE INDEMNIFICATION PROGRAM AT (503) 988-3035.

I hereby authorize Multnomah County Health Department and its representatives to consult with any and all third parties who have been associated with me and/or who may have information bearing on my qualifications and competence for approval as a volunteer health care provider with the Multnomah County Health Department. I hereby authorize and consent to the release of information concerning me to the Multnomah County Health Department and I release from liability all such persons, hospitals, or organizations complying with this request. I understand that this information is being requested as part of the credentialing process for volunteers.

Volunteer Signature _____ **Date** _____

THE FOLLOWING INFORMATION MUST BE PROVIDED BY THE VOLUNTEER APPLICANT'S CURRENT CLINICAL SUPERVISOR, OR, IF THERE IS NONE, TWO COLLEAGUES HAVING KNOWLEDGE OF THE APPLICANT'S PROFESSIONAL PRACTICE.

How long have you known the applicant professionally? _____

In what capacity have you known the applicant? _____

To your knowledge, has any disciplinary action ever been taken against the applicant?

☐ Yes ☐ No If yes, explain below:

Comments: _____

_____

_____

Has the applicant displayed possible dependence on drugs or alcohol that would, in your opinion, affect his or her ability to perform professional and medical staff duties?

☐ Yes ☐ No If yes, explain below:

Comments: _____

_____

_____

_____

Does the applicant have any physical or mental conditions that would, in your opinion, impair his or her ability to practice medicine?

☐ Yes ☐ No If yes, explain below:

Comments: _____

_____

_____

_____

Please rank (place a check mark at the right) the applicant in the following areas:

	Outstanding	Acceptable	**Unacceptable	Not Observed
Clinical Knowledge and Judgement				
Ethical conduct				
Respect for Peers				
Record keeping				
Relationships with patients				
Ability to work with staff & patients from various ethnic and language cultures				

** Provide comments regarding any unacceptable ratings: _____

_____

☐ Recommend without Reservations ☐ Do not recommend

☐ Recommend with the following reservations:

_____

_____

_____

_____

Signature: _____ Date: _____

PLEASE RETURN THIS DOCUMENT VIA FAX TO:

MULTNOMAH CO. HEALTH DEPT. (503) 988-3035 attn Terry