BSP-Free Clinic

Specialist and Nursing Volunteer Application

Date______________

Please Circle

MD/DO ***PA*** ***NP*** ***PT*** ***RN*** ***LPN*** ***Other:*** ______________________

Name: ____ DOB: __________________

Address: ______________________________________ Phone:__________________

City: ____________________________Zip:__________Email:__________________

Medical School/Other: ________________________Year Graduated:____________

Residency and Fellowship: ____*(if applicable)*

Please Circle:

Active Practicing **Semi-Retired** **Retired**

Last or Current Practice Location: ____

Address: _______________________________________ Phone: ___________________

Professional License #_____________________________
Exp. Date_________________

Physicians/PA- indicate specialty:____

☐ Please check box if any previous restrictions on professional license, prescribing disciplinary action

If so, when: ____________________________________

Emergency Contact: ____________________________ Phone: ________________ Relationship: ______________________________

***Please Submit via email: tricia.levenhagen@deancare.com ***

Applied for State Liability Coverage: *Yes* *No* *Date approved*____________