CASA DE SALUD
3200 Chouteau Ave., St. Louis, MO 63103 ● Phone 314-977-1250 ● Fax 314-977-1255

APPLICATION FOR PROFESSIONAL VOLUNTEER PRACTICE

Dear Future Colleague:
Thank you for your interest in volunteering as a medically-licensed provider at Casa de Salud. We depend on volunteer health professionals in order to meet the needs of our patients and fulfil our mission.

What is Casa de Salud?
Casa is a welcoming place that facilitates ongoing patient-centered health care. As such, Casa provides –

- Medical care for episodic and chronic conditions;
- Limited specialty care and health education
- Basic screening and prevention services
- Therapy and counseling services through our Mental Health Collaborative
- Volunteer Interpreters for all English-speaking providers to communicate with their patients

Casa also provides *medical case management* for health needs unable to be met at Casa, including:

- Referrals to other health care facilities
- Navigation (accompaniment) to appointments at other health care facilities
- Support with financial assistance for health care

Casa de Salud's Mission
To facilitate and deliver basic high quality clinical and mental health services for uninsured and underinsured patients, focusing on new immigrants and refugees who encounter barriers to accessing other sources of care.

Casa de Salud believes that…

- our patients are our first priority.
- we should serve our patients using a volunteer professional staff who deliver care with integrity, compassion, respect, and dignity for all.
- health and wellness include physical, mental, social, emotional, spiritual and environmental health.
- we should not duplicate existing local services and should assist patients in finding care within the St. Louis healthcare system.
- we should be good citizens in the healthcare community, maintaining strong ties with other providers to promote health and wellness for all of our people.

I understand Casa's Mission, Beliefs, and Practices, and agree to provide care in accordance with them:

_____	_____	_____
Signature	**Name**	**Date**

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CASA de SALUD

HEALTHCARE PROFESSIONAL APPLICATION CHECKLIST

- ☐ Application for Professional Volunteer Practice (pages 1, 3-6)
- ☐ Confidentiality Form (page 7)
- ☐ Photo Release Form (page 8)
- ☐ CV or resume
- ☐ Copies of professional licenses and other certifications (submit at initial application and at each relevant renewal)
    - ☐ Current Missouri full, permanent professional License
    - ☐ Board Certification(s) (if applicable)
    - ☐ Current DEA (if applicable)
    - ☐ Current BNDD (if applicable)
- ☐ Complete background check through Saint Louis University (Instructions page 9)
- ☐ Documentation of TB screening within past 12 months (may obtain at Casa)
- ☐ Documentation of Hepatitis B immunity
- ☐ Documentation of HIPAA training within the past 12 months (may obtain at Casa)
- ☐ Documentation of Blood Borne Pathogen training within the past 12 months (may obtain at Casa)
- ☐ Spanish Proficiency Assessment if planning not to use an interpreter (schedule with Casa staff)

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PERSONAL INFORMATION : **DATE: _____**

NAME: _____

LAST CREDENTIALIALS, FIRST MIDDLE

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

CURRENT ADDRESS: _____

PREFERRED PHONE #(S): _____

OFFICE CELL HOME

PREFERRED EMAIL ADDRESS: _____

How did you hear about volunteering at Casa:

AREA OF PROFESSIONAL EXPERTISE

- ☐ Physician – Specialty:_____ NPI: _____
- ☐ Nurse Practitioner, NPI: _____
- ☐ Physician's Assistant, NPI: _____
- ☐ Registered Nurse
- ☐ Registered Dietician
- ☐ Physical Therapist
- ☐ Other: _____

AVAILABLE HOURS

Please Note: Casa de Salud typically schedules volunteer providers for 2-3 hour shifts in the morning (9am - 12pm), afternoon (1pm - 4pm), or evening (4pm - 6pm) for example. *Specify exact times available*

FREQ: ☐ DAILY ☐ WEEKLY ☐ MONTHLY ☐ OTHER	MORNING	AFTERNOON	EVENING
SUNDAYS:			
MONDAYS:			
TUESDAYS:			
WEDNESDAYS:			
THURSDAYS:			
FRIDAYS:			
SATURDAYS:			

EDUCATION AND RESIDENCY/FELLOWSHIP PROGRAMS

☐ **REFER TO CV OR RESUME (no need to complete if checked)**

Years	Institution	Degree/Certification	City	State

LICENSE AND BOARD CERTIFICATIONS

Please attach copies of current license, DEA, BNDD, and Board Certification, if applicable

LICENSE #	STATE (MO required)	EXPIRATION DATE
BOARD CERTIFICATION(S)		EXPIRATION DATE

Are you registered with St. Louis County's Prescription Drug Monitoring Program?

☐ **Yes** ☐ **No**

CURRENT AND PAST PRACTICE

☐ **REFER TO CV OR RESUME (no need to complete if checked)**

Years (From-To)	Name of Practice	Address	City/State/Zip	Phone

NAMES OF THREE PROFESSIONAL REFERENCES

Name	Phone Number	Email

LANGUAGES: BILINGUAL/MULTILINGUAL

SPANISH: Yes ◯ No ◯	Please Schedule Proficiency Assessment if not planning to use an interpreter.
OTHER: (Specify):	PROFICIENCY (Circle One): Rudimentary ◯ Basic ◯ Advanced ◯ Bilingual ◯

IN CASE OF EMERGENCY NOTIFY

NAME	ADDRESS	PHONE

PLEASE RESPOND TO THE QUESTIONS BELOW. IF THE ANSWER TO ANY QUESTION IS YES, PROVIDE A DETAILED EXPLANATION ON A SEPARATE PAGE(S):

1. Have you ever been the subject of a disciplinary or investigative proceeding or been reprimanded by a governmental or administrative agency, hospital or professional association?

   YES NO

2. Have you ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?

   YES NO

3. Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?

   YES NO

4. Have you had any state professional license, board certification, or license to prescribe or dispense narcotics challenged, refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?

   YES NO

_____ _____ _____

Printed Name Signature Date

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PHYSICIAN & HEALTHCARE PROVIDER AUTHORIZATION, ATTESTATION AND RELEASE

In connection with applying to serve as a volunteer physician or provider at Casa de Salud, I agree to the following.

AUTHORIZATION. I authorize and grant consent to Casa de Salud and its agents to obtain a consumer report or an investigative consumer report. The report may include inquiries to federal and state law enforcement agencies (e.g., criminal background checks), each licensing board from which I have been issued a license, and the National Practitioner Data Bank as part of an evaluation of my credentials for practice as a volunteer physician of Casa de Salud. I further authorize Casa de Salud and its agents to consult with and, if necessary, obtain and review documents from current and previous employers, malpractice carriers (including, but not limited to, claims history), managed care companies, hospitals or other health care facilities, educational institutions, and persons or entities who have been associated with me and/or who may have information bearing on my competence, character, general reputation, personal characteristics, mode of living, qualifications or professional conduct or that is otherwise relevant to my practice as a volunteer physician or provider of Casa de Salud. Upon the request by Casa de Salud or its agents, I agree to complete and sign any forms or documents as may be required by third parties in order to carry out the purposes of the authorizations granted herein. The authorization granted in this paragraph expires one (1) year from the date set forth by my signature below.

ATTESTATION. I certify that all information provided on this form, on the Application for Professional Volunteer Practice, in any information otherwise provided by me to Casa de Salud, and all other representations previously made by me to Casa de Salud are true, correct and complete and are not misleading. The terms of this paragraph survive termination of the authorization above.

RELEASE. I release Casa de Salud from any liability in connection with conducting a review of my background as contemplated above and/or for relying on any information provided by me or by individuals and organizations pursuant to the Authorization above, including information concerning my credentials, professional competence, ethics, character and other qualifications for practice as a volunteer physician or provider of Casa de Salud. The terms of this paragraph survive termination of the authorization above.

*Either an original or a photocopy of this form to be used for the purposes set forth herein.

_____	_____	_____
Printed Name	Signature	Date

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VOLUNTEER CONFIDENTIALITY AND NON-DISCLOSURE AGREEMENT

(signed copy to be kept in volunteer file.)

I, _____, do affirm that I will not divulge *CASA DE SALUD* data to any unauthorized person for any reason. Neither will I directly nor indirectly use, or allow the use of, *CASA DE SALUD* data for any purpose other than that directly associated with my volunteer assigned duties. I understand that ALL PATIENT INFORMATION, including financial data, is strictly confidential.

Furthermore, I will not – either by direct action or by counsel – discuss, recommend or suggest to any unauthorized person the nature or content of any *CASA DE SALUD* information.

I agree that any violation of this agreement is cause for termination.

I understand that signing this document does not preclude me from reporting instances of breach of confidentiality.

_____	_____	_____
Printed Name	Signature	Date

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AUTHORIZATION FOR RELEASE AND USE OF VOLUNTEER IMAGE

(Signed copy to be kept in volunteer file.)

I _____, hereby authorize *Casa de Salud*, or its designee, to:

1. to use my image, including but not limited to, my name, photograph, picture, portrait, digital image, video, likeness, statements and voice (hereinafter collectively known as my "Image"), for the purpose of *Casa de Salud* publicity and educational purposes;

2. to use, reproduce, publish, exhibit, distribute, and transmit my image individually or in conjunction with other images or printed matter, including but not limited to video tapes, sound recordings, still photographs, digital reproductions, or any other form of media;

3. to record, reproduce, amplify and simulate my image and all sound effects produced;

4. to assign the above-mentioned rights to third parties.

I hereby waive the right to inspect or approve my image or any finished materials that incorporate my image. I understand and agree that I will receive no compensation, now or in the future, in connection with the use of my image.

I hereby release and forever discharge *Casa de Salud*, its Trustees, officers, agents and employees from any and all claims, demands, rights and causes of action of whatever kind that may arise from the use of my image, including but not limited to, all claims for defamation and invasion of privacy.

This authorization shall exist in perpetuity unless I specifically revoke my authorization in writing as explained in the *Casa de Salud* notice of privacy statement. I understand that my volunteer work or practicum will not be affected if I do not sign this form. I understand that federal privacy regulations may no longer protect the use of my image once *Casa de Salud* utilizes my image.

Name (please print): _____ Date: _____

Signature: _____ Phone Number:_____

Casa de Salud Representative Name: _____

Casa de Salud Representative Signature: _____

CRIMINAL BACKGROUND CHECK THROUGH SAINT LOUIS UNIVERSITY (SLU)

Casa de Salud utilizes the background check services of Saint Louis University through the Office of the University Registrar. Please visit this link to initiate your background check authorization. The criminal background check takes approximately 2-4 weeks to be fully completed. Detailed instructions are below:

Steps to completing a background check through SLU Offices of the University Registrar:

1. Follow this link to DocuSign. You will be prompted to put in your name and email and should receive a validation code. Enter the code and select "Validate".
2. Check the box next to the yellow tab to agree to use electronic records and signatures. Select "Continue".
3. Fill in the online Authorization Form with electronic signature.
    1. For the Associated SLU Department, select "Casa de Salud".
    2. If you are associated with the University and have a Banner ID, you may enter it. If not, please put "N/A" for that field.
4. Electronically sign the document (page 1) and select "Finish".

Casa de Salud will be invoiced for the background check, there is no up-front cost to the applicant. Upon successful completion of the authorization form, you will receive an email confirmation with further instructions.

For questions about the criminal background check, please contact the Office of the University Registrar, 314-977-2269 or registrar@slu.edu.

For all other questions, please contact the Clinical Services Manager,Leonor Roy, 314-977-1266 or lroy@casadesaludstl.org.

Have you completed a criminal background check in the last 6 months?
If you have completed some or all of the items included in the University's criminal background check and can provide a copy of your results, please include with your application for review.