



Volunteer Health Care Provider Program (VHCPP)
APPLICATION FOR A VOLUNTEER HEALTH CARE PROVIDER PROGRAM CONTRACT

CLINIC: We Care of Central Florida, Inc.

Provider Name: (Please Print) (Last) (First) (Middle)

Address: (Please Print) (Street) (City) (State) (Zip)

Phone Number: (Area code) E-mail: (Please Print)

Occupation: Specialty: FL License Number:

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 affiliated

Signature: Date:

Printed Name of Professional Association:

FEI or Document Number:

Printed Name and Title of Corporate Officer/Director with Contract Authority:

Business Address: (Street) (City) (State) (Zip)

Phone Number: ()

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: Signature of VHCPP Regional Coordinator Date

Return application form to: We Care of Central Florida, Inc. Attn: Heather Stephenson, CEO
Email: Heather@wecarecentralflorida.org or Fax (863) 662-4799