FOR OFFICE USE ONLY
Physician Volunteer Checklist

- ☐ Application
- ☐ License Verification
- ☐ Sponsoring Agency Letter
- ☐ Continuing Education Compliance

*****FOR OFFICE USE ONLY*****

ID #

Issue Date

License #

Rhode Island
Board of Medical Licensure and Discipline

Room 205
3 Capitol Hill
Providence, RI 02908-5097

License # _____

Name _____

Instructions and License Application for:

Volunteer License

☐ MD ☐ DO

Obtained By:

☐ RI License - License Number _____

☐ Endorsement - State_____ License No._____

Applicant - Print Name (First/MI/Last)

Phone: (401) 222-3855 **TTY/TDD: (800) 745-5555** **Fax: (401) 222-2158**

Revised 09/16/2014 jcp

GENERAL INFORMATION

Enclosures

Pursuant to Chapter 5-37.1 of the General Laws of the State of Rhode Island:

(1) The Rhode Island Board of Medical Licensure and Discipline may issue a volunteer license to qualifying physicians under the terms and conditions set forth in this section

(2) The volunteer physician licensee shall be permitted to practice medicine only in the non-compensated employ of public agencies or institutions, not-for-profit agencies, not-for-profit institutions, nonprofit corporations, or not-for-profit associations which provide medical services.

(3) The person applying for the volunteer license under this section shall submit to the board a statement from the sponsoring agency, institution, corporation, association or health care program whereby he or she agrees unequivocally not to receive compensation for any services he or she may render while in possession of this volunteer license.

(4) Any application fees and all licensure and renewal fees shall be waived for the holder of this volunteer license.

(5) A physician licensed pursuant to this section shall comply with the continuing education requirements established by the board in the state in which they are licensed.

Application Process

Complete and submit application along with the following:

1. Evidence of continuing medical education for the past 2 years

2. National Practitioner Data Bank Self-query
   http://www.npdb.hrsa.gov/pract/selfQueryBasics.jsp

3. Statement from the sponsoring agency whereby it is agreed between the parties that no compensation shall be paid for any services rendered while in possession of this volunteer license and that malpractice insurance is in place.

Complete all pages of the application. Do not submit applications without all applicable information and documentation. Mail these components of the application to:

Rhode Island Board of Medical Licensure and Discipline
Room 205
3 Capitol Hill
Providence, RI 02908-5097

APPLICATION PROCESS OVERVIEW

HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others. Once completed, the application will be reviewed, and you will be contacted in writing.

Please continue to review the remaining portions of this application packet for instructions and other materials necessary to complete the Board application. If you have any questions about this application process, or would like to check on the status of your Board application, please contact this office at (401) 222-3855.

General Instructions

1. Make a copy of the application and forms before you begin, in case you make a mistake.

2. Type your information or print in blue or black ball-point pen. Board staff will not make assumptions about illegible information. Be sure to print your name in the box provided on the cover page.

3. Provide a response to each section or question; otherwise, mark "N/A" for Not Applicable.

4. We suggest that you make a copy of your completed application before submitting it to the Board.

5. **It is your responsibility to check on the status of your application on the verifications page of the Department of Health website at: www.health.ri.gov**

APPLICATION CHECKLIST

Please review the following checklist to ensure you have satisfied all components of the application process. I have arranged my Board Application materials in the following order.

1. Board Application
2. Evidence of continuing medical education for the past 2 years
3. Statement from the sponsoring agency whereby it is agreed between the parties that no compensation shall be paid for any services rendered while in possession of this volunteer license and that malpractice insurance is in place.

State of Rhode Island
Board of Medical Licensure and Discipline

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)

This is the name that will be printed on your License/Permit/ Certificate and reported to those who inquire about your License/ Permit/ Certificate. Do not use nicknames, etc.

All questions MUST be answered. Enter "NA" for any question that is NOT APPLICABLE.

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Degree (DMD,DDS)

Maiden, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

2. Social Security Number

U.S. Social Security Number

"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Divison of Taxation to verify that no taxes are owed to the State."

3. Home Address

It is your responsibility to notify the board of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

State

Zip Code

Country, If NOT U.S.

Postal Code, If NOT U.S.

Home Phone

Home Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

4. Sponsoring Agency Name and Address

If sponsored by more then one agency, please attach a separate sheet with the required information.

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

State

Zip Code

Country, If NOT U.S.

Postal Code, If NOT U.S.

Business Phone

Extension

Business Fax

It is your responsibility to notify the board of all locations where you will be providing services. A statement from each sponsoring agency, institution, corporation, association or health care program, whereby he or she agrees unequivocally not to receive compensation for any services he or she may render while in possession of this volunteer license.

5. Affidavit of Applicant

Complete this section and sign in the presence of a notary public.

Make sure that you and the notary public have completed all components asdfaccurately and completely.

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____, by _____,
(Applicants Name)

who is personally known to me or has produced _____,
(i.e. license/ID, etc.)

as documentation and did/ did not take an oath.

Notary Seal

_____
Applicant's Signature

_____
Notary Public

Rhode Island Board of Medical Licensure and Discipline
Room 205, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-3855

STATEMENT OF SPONSORING AGENCY

I,_____ , Director _____
(Agency Representative) (Sponsoring Agency)

_____
Agency Address Street City ZipCode

Have entered into a contract with_____ who agrees
(Physician Name)

unequivocally not to receive compensation for any services he or she may render under this volunteer license. This volunteer license permits the practice of medicine only in the non-compensated employ of public agencies or institutions, not-for-profit agencies, not-for-profit institutions, nonprofit corporations, or not-for-profit associations. Malpractice insurance is provided for the physician as well.

_____ _____
Physician Signature Director's Signature

_____ _____
Date Date

Affidavit of Sponsoring Agency

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____, who is personally known to me or has produced _____, as documentation and did/did not take an oath.
(i.e. license/ID, etc.)

Notary Seal

_____
Notary Public