RETIRED PHYSICIAN IMMUNITY ACT
APPLICATION FORM

Name of Clinic:
County:
Street Address:
City, State, Zipcode:
Telephone:
Fax:

This program **DOES [ ]** **DOES NOT [ ]** receive third party (medical insurance) reimbursement for medical services provided to patients/clients. **Provide a copy of the most recent financial report or auditor's statement as documentation.**

Volunteer physician's listing	Medical Specialty

(Provide an additional sheet if required)

Attach a copy of the clinic's mission statement to provide free or low cost services; statement or signed agreement of volunteer status (not receiving financial or other compensation) of retired physicians delivering services; the medical license of all volunteer retired physicians; and the clinic's policy for notifying patients that volunteer physicians rendering medical services are immune from civil suit.

______________________________ ______________________________
Clinic Administrator **Date**

For Office Use Only

Date Received: ____________________
Date **Approved [ ]** **Disapproved [ ]** ____________________
Date Approval terminated: ____________________

______________________________ ____________________
Approval Signature Date