Oklahoma Volunteer Charitable Health Care Provider Contract Request

Provider Information

Prefix

- [ ] Mr.
- [ ] Ms.
- [ ] Dr.

Provider Name

First Name:

Middle Initial:

Last Name:

Provider's Office or Home Address where your contract package will be sent.

Address

- ◯ Home
- ◯ Office

Address:

Address 2:

City:

State:

Zip Code:

Email Address:

Phone:

Please indicate if you wish to have your contract package mailed to an alternate address by providing this information below.

Alternate Name:

Alternate Address:

Alternate Address 2:

Alternate City:

Alternate State:

Alternate Zip Code:

Alternate Email Address:

Alternate Phone:

Please indicate your provider designation.

Provider Description

Primary Description:

- [ ] MD
- [ ] DO
- [ ] DDS
- [ ] RPH
- [ ] PA
- [ ] APRN
- [ ] RN
- [ ] LPN
- [ ] OT
- [ ] PT
- [ ] OTHER

Other (please specify):

Please select the Oklahoma agency that issued your license or authorization to provide health care services that is relevant to your application to enter into a contract with the Oklahoma state Department of Health to be a charitable health care provider:

Issuing Agency:

- [ ] Oklahoma Board of Medical Licensure and Supervision
- [ ] Oklahoma State Board of Osteopathic Examiners
- [ ] Oklahoma State Board of Dentistry
- [ ] Oklahoma Board of Nursing
- [ ] Oklahoma State Board of Pharmacy
- [ ] Oklahoma State Department of Health

Please provide the License or Certification Number(s) and Date of Expiration. If you have more than one number to enter, separate entries with a semicolon(;).

License or Certification Number:

Date of Expiration (MM/DD/YYY):

Please attach a summary of any professional discipline assessed against you as a health care provider in the last five years, including what the specific discipline was and the underlying basis for such discipline.

Professional Discipline:

- [ ] Attached
- [ ] Not Applicable

I authorize the Oklahoma agency that issued my professional license or other authorization to provide health care services in Oklahoma to inform the contracting agency**, upon its inquiry, of the status of my license or authorization, including whether my license is in good standing, for the purpose of processing this application.

Signature of Applicant:

Please identify your professional malpractice insurance carrier for the last five years:

Have you had any professional malpractice claims brought against you within the last five years?

Professional Malpractice:

- [ ] Yes
- [ ] No

If yes, please provide your claims history for any claim(s) brought against you within the last five years by attaching the claims information to this application. Minimally, the claims history must include the contact information of the reporting entity, the number of claims, a brief description of each claim, the type of health care services being provided that precipitated each claim, and the money that was paid, or is being paid, per claim, if any.

I authorize my professional malpractice insurance carrier to inform the contracting agency or the Risk Management Division of the Office of Management Enterprise Services Division of Capitol Assets Management, upon its inquiry, regarding any claims history for the last five years for the purpose of processing this application.

Signature of Applicant

Please indicate the Charitable Health Care Clinics you are Associated with. You may enter up to five clinics.

Clinic 1:

Clinic 2:

Clinic 3:

Clinic 4:

Clinic 5:

Please estimate how many hours per month you may participate as a charitable health care provider.

I hereby certify that the information provided in this application, including any attachments, is true and accurate to the best of my knowledge.

Signature of the Applicant:

Date (MM/DD/YYYY)

If you prefer to submit this information by hard copy, please print this page and return the application to:

Oklahoma Volunteer Charitable Health Care Provider Program
Oklahoma State Department of Health
Office of Primary Care and Rural Health Development, Rm 915
1000 N.E. 10th Street
Oklahoma City, OK 73117
For Questions or Comments Call:
(405) 271-9444 ext. 56586
Email: OkOPC@health.ok.gov