

Department of Health
Volunteer Health Care Provider Program
Application for Sovereign Immunity

(Please print or type the information requested on this application.)

Name: Practice Name:

Mailing Address:

City/State: Zip Code: Phone: Fax:

Social Security #: Date of Birth:

Provider Type: Specialty:
(Physician, Dentist, Hygienist, ARNP, , etc.)

Florida License #:

Medicaid Provider #: Medicare Provider #:

I understand that a routine check of my name through the Department of Professional Regulation, and the Department of Health files will be made. I further understand that sovereign immunity applies only for those patients found eligible and referred by the Department of Health and who have completed the notice to patient pursuant to Florida Statute 766.1115.

Volunteer Location:
(Private Practice Office, Community Based Clinic, Special Event, other (please indicate))

Signature: Date:

(Please mail completed application to: Tony Campo, 224 SE 24th Street, Gainesville, Florida 32641)

FOR DEPARTMENT USE ONLY

Verification of Credentials:

Current Florida Health Professional License: Yes No Hospital Credentialed: Yes No
Under investigation, probation, or suspension: Yes No Specify:
HCFA sanctions for Medicaid/Medicare Violations: Yes No
Credentialing Completed By: Date:

APPLICATION STATUS: APPROVED DENIED

Date: