DEPARTMENT OF STATE
HEALTH LICENSING DIVISION
P O BOX 2649
HARRISBURG, PA 17105-2649

Telephone:
1-833-367-2762

Website: www.dos.pa.gov

VOLUNTEER LICENSE APPLICATION

1. Complete the following form, attach the official letter and read the regulations. A fee is not required.

2. A Volunteer License is "a license issued by the appropriate board to a health care practitioner who documents, to the board's satisfaction, that the individual will practice only in approved clinics, or upon referral from approved organizations, without remuneration, who is:

   a) A retired health care practitioner; or

   b) A non-retired health care practitioner who is not required to maintain professional liability insurance under the act of March 20, 2002 (P.L. 154, No.13), known as the Medical Care Availability and Reduction of Error (Mcare) Act, because the health care practitioner is not otherwise practicing medicine or providing health care services in this Commonwealth."

NAME: _____
(LAST) (FIRST) (MIDDLE)

OTHER NAMES USED: _____

ADDRESS: _____
(NUMBER & STREET) (CITY) (STATE) (ZIPCODE)

SOCIAL SECURITY NUMBER: _____ **DATE OF BIRTH:** _____
(MM/DD/YYYY)

NAME OF CLINIC OR ORGANIZATION WHERE YOU WILL BE PRACTICING:

_____

ADDRESS OF CLINIC OR ORGANIZATION:

_____
(NUMBER & STREET) (CITY) (STATE) (ZIPCODE)

LICENSE TYPE: _____ **PA LICENSE NUMBER:** _____
(One per application) (If unable to provide license number, contact Board office for instructions)

NAME: _____

(LAST) (FIRST) (MIDDLE)

APPLICANT must meet one of the following criteria in order to apply for a volunteer license (Check one):

□ A licensee in good standing who has retired from active practice; OR

□ A non-retired licensee who does not otherwise currently practice or provide health care services in this Commonwealth and is not required to maintain professional liability insurance under the Medical Care Availability and Reduction of Error (Mcare) Act.

I CERTIFY THAT I INTEND TO PRACTICE ONLY:

1. **IN AN APPROVED CLINIC OR ORGANIZATION, AND**
2. **WITHOUT PERSONAL REMUNERATION FOR PROFESSIONAL SERVICES.**

Attach an official letter on letterhead signed by the director or chief operating officer of an approved clinic or organization that states you have been authorized to provide volunteer services in the named clinic or organization by the governing body or responsible officer of the clinic or organization. If you change clinics or organizations, please submit an updated letter to the Board. The updated letter must identify your Volunteer License number.

NOTICE: Disclosing your Social Security Number on this application is mandatory in order for the Board to comply with the requirements of the Federal Social Security Act pertaining to Child Support Enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S. §4304.1(a) (relating to cooperation of government and nongovernment agencies). At the request of the Department of Human Services (DHS), the licensing boards must provide to DHS information prescribed by DHS about the licensee, including the social security number. In addition, Social Security Numbers are required in order for the Board to comply with the reporting requirements of the U.S. Department of Health and Human Services, National Practitioner Data Bank.

VERIFICATION

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that any false statements made are subject to the penalties of 18 Pa.C.S. §4904 (relating to unsworn falsifications to authorities) and may result in the suspension, revocation or denial of my license or certificate. I verify that this form is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information pursuant to 18 Pa.C.S. §4911 (relating to tampering with public records or information).

_____ _____

Signature of Applicant Date

_____

Printed Name of Applicant