

Surgery On Sunday, Inc. 650 Newtown Pike Lexington, Kentucky 40508

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Laura Ebert, Executive Director; Terri Cline, Client Coordinator



PHYSICIAN VOLUNTEER APPLICATION

(APPLICATION MUST BE COMPLETED IN ITS ENTIRETY IN ORDER TO BE PROCESSED)

Last Name: _____ First Name: _____

Address: _____

Email: _____

Phone: _____ Cell: _____ Pager: _____

Medical License Number: _____ Social Security Number: _____

Please Include Copy of MD License

Date of Birth: _____ Fluent Languages: _____

Specialty: _____

Employer/Practice: _____

Release of Information Authorization

I _____ hereby give Surgery On Sunday, Inc. permission to ascertain information and or documents from credentialing hospitals and agencies in regards to my professional licensures and standing to be used for Surgery On Sunday, Inc. purposes only.

APPLICANT SIGNATURE

DATE

Surgery On Sunday, Inc. Confidentiality Agreement

Surgery On Sunday, Inc. follows and adheres to all professional medical guidelines including the Health Information Portability and Accountability Act (HIPAA) of 1996. As a Surgery On Sunday, Inc. volunteer I understand and agree that all information pertaining to Surgery On Sunday, Inc. patients and volunteers must be kept strictly confidential. Any violation of this agreement will result in my immediate termination as a Surgery On Sunday volunteer and may involve legal repercussions.

I will not hold Surgery On Sunday, Inc. or any Surgery On Sunday staff member, volunteer or patient liable for any personal injury or loss of personal property while participating in the Surgery On Sunday, Inc. volunteer program.

Volunteer Signature

Date

Witness Signature

Date