PARTICIPATION AGREEMENT FOR VOLUNTEERS

Physician and Group Name

Address *(street, city, state, zip)*

Office Phone | Fax | Contact Email

Specialty or Focus of Practice | Washington Medical License #

Office Manager *(Project Access Contact)* | Manager's Phone | Manager's Email

ANNUAL COMMITMENT

It is the intent of the above named physician, other health care provider or group to provide care to patients enrolled in Project Access Clark County on a volunteer, pro bono basis until further notice. It is mutually understood that this commitment is voluntary, revocable, and subject to modification by the clinician or group at any time. Project Access Clark County will make a bona fide effort to provide coordination of patient care with other professionals or institutions and balance the efforts of its volunteers.

If your specialty is office based, at what level can each practitioner conditionally commit to care for Project Access Clark County patients? Patients (cases) per year: ______________________________

Special Interests & Skills *(Languages Spoken)*: ______________________________

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Exclusions: ______________________________

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I have Hospital Privileges at: ______________________________

Referred to Project Access Clark County by: ______________________ *(allow us to say thank you!)*

By signing here I agree to participate in Project Access Clark County

Signature | Date

PLEASE RETURN FORM TO:

Free Clinic of SW Washington • 4100 Plomondon St. • Vancouver, WA 98661
Phone 360|313|1384 • Fax 360|313|1391 • www.projectaccessnow.org

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