



**Volunteer Provider Profile Form  
Hope Medical Outreach Coalition**

***Please complete and fax to: 345-2413***

Name: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

Zip: \_\_\_\_\_

E-mail: \_\_\_\_\_

Retired:     YES                       NO

Specialty : \_\_\_\_\_

Office Contact Person: \_\_\_\_\_

Name of Malpractice Carrier and Limits of Liability: (attach a copy): \_\_\_\_\_

**Family Practice and Internal Medicine Physicians:**

*Would you be willing to volunteer for a block of 2 to 3 hours on a regular basis at the community clinics (Charles Drew, OneWorld, or Siena-Francis House)?*

Yes                      **Clinic Preference:** \_\_\_\_\_

**Where would you prefer to do surgery or procedures? (Check all hospitals)**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> All Alegent Hospitals | <input type="checkbox"/> Creighton Univ. Medical Center | <input type="checkbox"/> Midlands                              |
| <input type="checkbox"/> Bergan Mercy          | <input type="checkbox"/> Immanuel                       | <input type="checkbox"/> NHS/ University/Clarkson              |
| <input type="checkbox"/> Boys Town Research    | <input type="checkbox"/> Jennie Edmundson               | <input type="checkbox"/> Omaha Surgical Center                 |
| <input type="checkbox"/> Children's            | <input type="checkbox"/> Methodist                      | <input type="checkbox"/> Southwest Iowa Medical Center / Mercy |

**Are you affiliated with;**    UMA     CMA     Other Provider group \_\_\_\_\_

**If seeing Hope patients at your office, how many patient referrals would you consider accepting under this program?**

- One a week             One a month             Two to four per month             Call me as needed

**Are there specific days and/or appointment times you would prefer to see Hope patients?**

Monday       Tuesday       Wednesday       Thursday       Friday

Time: \_\_\_\_\_ am      \_\_\_\_\_ pm

Times will vary, please contact us

**With respect to patient profiles, what age patient are you willing to treat? Check all that apply.**

Children       Adults       Elderly

**Will you see special needs patients?**  Yes

**Would you consider reserving a block of 3 to 4 hours in your office for Hope patients on a regular (e.g. monthly) schedule?** (We will contact your office with more specific information)

YES       NO.

**What types of care and/or procedures are you willing to donate?**

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**Are you or your staff able to provide quality interpretation?**  YES       NO

Language(s) \_\_\_\_\_

**Is your office wheelchair accessible?**  YES       NO

**Physician's credentials are maintained through Nebraska Credentialing service.**

**Hope Medical Outreach Coalition  
1722 St. Mary's Ave, Suite 105  
Omaha, NE 68102  
(402) 345-2400  
Fax: (402) 345-2413**