



Dear Healthcare Professional,

Please find enclosed the credentialing application for healthcare professionals to provide services at the Volunteers in Medicine of Southern Nevada clinic.

**VMSN is applying for medical malpractice coverage for all healthcare professionals who work in our clinic through the federal government.** This coverage is thru the Federal Tort Claims Act (FTCA) and is similar to coverage that one would receive at military treatment centers, federal clinics and the VA system.

In order to secure FTCA coverage, VMSN requires that all professionals treating patients in the clinic have completed the attached application and been credentialed. For all healthcare professionals other than physicians this involves filling out the VMSN application , and then having our credentialing specialist verify your licensure/certification and complete a National Practitioner Data Base search.

If you have malpractice coverage through your job or a private agency, you may be covered by that policy for volunteer work. The federal government recommends that all healthcare professional volunteers, who have private liability insurance, obtain a letter specifically stating whether or not that professional volunteer has malpractice coverage at a free clinic. If you do , VMSN will credential you as above but will not submit your name for the formal FTCA application process. VMSN will instead require a copy of the letter sent straight to us from your insurer.

VMSN is run primarily by volunteers, and our services are completely free for patients. Since opening to the public on January 22, 2010, we are literally improving and even saving the lives of Clark County residents who have fallen through the cracks of our healthcare system. I look forward to receiving your completed application, and promise you that you will find working at VMSN a rich and rewarding experience.

Cordially,

*Laura Culley, M.D.*

Medical Director, VMSN



**VMSN INC.**

## **Healthcare Professional Application**

Prior to participation as a provider with VMSN, all healthcare practitioners must complete the credentialing procedure. Please send the information requested below to the following address:

**VMSN Inc.  
4770 Harrison Drive  
Suite 105  
Las Vegas, NV 89121**

Please complete and return the **Healthcare Professional Personal Data** form to meet FTCA requirements.

All practitioners must also provide copies of the following documents:

- 1. Government issued picture ID: driver's license or passport**
- 2. Current Nevada certification \_\_\_yes \_\_\_no Certification # \_\_\_\_\_**
- 3. Life support training (if applicable)**

In accordance with Program Information Notice 2004-24 (revised), hospitals or independent credentialing companies may serve as the Credentials Verification Organization (CVO). Also as required by the same Notice, all healthcare practitioners must submit a ten-year history of any malpractice claims.

As part of the credentialing process, providers have the following rights:

- 1. The right to review information submitted to support your credentialing application that is not protected by law;**
- 2. The right to correct erroneous information submitted to another party for use in the credentialing process and;**
- 3. The right to be informed of the status of your credentialing or re-credentialing application upon request.**

If you have any questions or concerns regarding your rights or your credentialing application, please call (702) 967-0530 or fax us at (702) 967-0538.



**VMSN INC.**

**HEALTHCARE PROFESSIONAL PERSONAL DATA**

1. Name \_\_\_\_\_
2. Other name(s) previously used \_\_\_\_\_
3. Social Security Number \_\_\_\_\_
4. Education: Please list schools attended, degrees/certification obtained and dates:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. License/certification number \_\_\_\_\_ Exp date \_\_\_\_\_
6. Please list states you are licensed/certified in: \_\_\_\_\_
7. Place of birth \_\_\_\_\_ Date of birth \_\_\_\_\_
8. Gender \_\_\_\_\_ Citizenship \_\_\_\_\_
9. If not US citizen: Visa # \_\_\_\_\_ Status \_\_\_\_\_ Exp date \_\_\_\_\_
10. Name of spouse/significant other \_\_\_\_\_
11. Local residence/address \_\_\_\_\_
12. Home phone number \_\_\_\_\_ Cell number \_\_\_\_\_
13. Email address \_\_\_\_\_
14. Any practice restrictions? \_\_\_\_\_
15. Languages spoken other than English \_\_\_\_\_