

Information Packet Preventive (Community) Medicine Rotation

In addition to those requirements outlined in the goals and objectives for this rotation, the following are additional requirements for this rotation and need to be completed and turned into the Residency Coordinator as soon as possible but **no later than 31 May** and are included in this packet.

- A **copy** of your current permanent or temporary Hawai'i license. **Out of state license not acceptable for this rotation.**
- Completion of the following Aloha Medical Mission Clinic forms:
 - Health Care Professionals Medical Questionnaire.
 - Licensed Independent Practitioner's Health Fitness Statement.
 - Request to Verify Medical/Dental Staff Membership and/or Privileges.
 - Waiver and release of Liability.
 - AAM Clinic Volunteer Application – Physicians, Surgeons & Dentists.
 - Memorandum of Understanding.

This packet was last updated on Friday, 15 May 2009.



ALOHA MEDICAL MISSION CLINIC

PALAMA SETTLEMENT

810 No. Vineyard Blvd., Honolulu, Hawaii 96817

Telephone: (808) 841-4489 Fax: (808) 841-4547

**HEALTH CARE PROFESSIONALS
MEDICAL QUESTIONNAIRE**

Today's Date _____

I, _____ verify that the information below is truthful and honest to the best of my knowledge.

PPD (TB Skin Test) Status

Date of most recent PPD (TB Skin Test) _____

Do you have a history of a positive PPD (TB Skin Test) ___ Yes ___ No,

If yes, date of last CXR _____

Immunization Status:

Please provide copy of Immunization history to include **(HEP. B)** Vaccines, titer results or declaration statement.

Allergies: _____

Are you allergic to Latex? ___ Yes ___ No, If Yes, describe reaction _____

Do you have any medical history or conditions that could cause you difficulties while working at the clinic? (i.e., insulin dependent diabetic or heart attack a year ago.)

If so, please explain:

Emergency Contact:

Name _____

Relationship _____

Address _____

Phone Contact _____



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Licensed Independent Practitioner's Health Fitness Statement

Applicant/Practitioner Name: _____

Title _____

Date of Birth _____

I _____ (applicant's/practitioner's name) attest that I am fit to perform the care, treatment and other services provided at *Aloha Medical Mission Honolulu Clinic*. Further, the substantiation of this fitness may be confirmed by the Clinic's dental/medical director, the hospital where I may be privileged or any other individual designated by the organization.

I further attest that I meet ongoing continuing education requirements not only to maintain any licensure or certification, but also to maintain practice skills and knowledge in the specific scope/content of patient care services I provide to patient's at *Aloha Medical Mission Honolulu Clinic*.

Applicant/Practitioner Signature

Date

Applicant/Practitioner to complete above ONLY

I confirm that the above individual is:

- Fit to provide services at Aloha Medical Mission Honolulu Clinic without limitation
- Fit to provide services at Aloha Medical Mission Honolulu Clinic under the following conditions:

Signature of Confirmation

Print Name & Title

Date

Address

City

State

Zip

Request to Verify Medical/Dental Staff Membership and/or Privileges

Date _____

TO: AMM Clinic Credentialing Coordinator

RE: **Verify Hospital/Institution Membership and/or Privileges**

APPLICANT/PRACTITIONER _____
Print Name and Title

AUTHORIZATION AND CONSENT TO VERIFY MEDICAL/DENTAL STAFF MEMBERSHIP AND/OR PRIVILEGES

I hereby authorize and release from any liability any and all individuals and organizations that provide information to **The Aloha Medical Mission Honolulu Clinic** or its representatives concerning my professional competence, character, ethics, and other qualifications for employment and/or privileges and I hereby consent to the release of such information.

Signature of Applicant/Practitioner

Date

The above applicant/practitioner is authorizing you to provide information concerning his/her medical/dental membership and/or privileges for **The Aloha Medical Mission Honolulu Clinic** use in considering his/her request for privileges to volunteer at the Clinic. This information is requested at the direction of the Aloha Medical Mission Credentialing Committee and will become a part of the practitioner's Confidential File. Please complete this portion of this form and forward to the below assigned Credentialing Coordinator.

Signature of Aloha Medical Mission Honolulu Medical Director

Below to be completed by Hospital/Organization/CVO Agent:

Medical/Dental Staff Status: Active Other: _____

Dates of Medical/ Dental Staff Membership ___/___/___ to ___/___/___

Privileges granted in the practice/scope of service of _____

The following primary source verification has been obtained per JCAHO standards and supporting documentation is attached

- a) Current licensure;
- b) Relevant education, training, or experience.

Signature of Hospital/Organization/CVO Verifying Agent

Date



Aloha Medical Mission

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Email: info@alohamedicalmission.org
Website: www.alohamedicalmission.org

WAIVER AND RELEASE OF LIABILITY

I hereby release the Aloha Medical Mission, its officers, employees and Board of Directors from any and all liability for any acts or omissions related to the rendering of medical, dental, and other appropriate healthcare services to the patients in the Aloha Medical Mission Clinic-Honolulu as of this date _____.

I fully understand that there may be risks of accident, injury or disease, which may be caused by my own actions or inaction, the actions or inaction of the Aloha Medical Mission or others, or the conditions at the location where the Clinic is located. There may be other potential risks either not known to me or not readily foreseeable at this time. I fully accept and assume all such risks and all responsibility for losses or damages I may incur due to my participation at the Aloha Medical Mission Clinic-Honolulu. I certify that I am qualified, in good health, and proper physical condition to volunteer.

I further hereby waive and release any and all rights and claims for loss or damage, at law or in equity, that I may have against the Aloha Medical Mission, its officers, employees, volunteers and Board of Directors now or in the future for any and all illness, injury, loss or damage suffered by me as a result of my participation at the Aloha Medical Mission Clinic-Honolulu, even if the loss or damage is caused by the person I am releasing. This waiver and release is binding on my heirs, successors, assigns, personal representatives, administrators and executors.

I certify that I have read the contents of this document, fully understand its provisions, and freely execute this waiver and release.

DATED in _____, this _____ day of _____, 20_____.

Name (Please PRINT.)

Signature



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AMM Clinic Volunteer Application - Physicians, Surgeons & Dentists

(Please type or print clearly. Use black or dark blue ink only.)

Name: _____ Gender: F M Date of Birth: _____

Mailing Address: _____

Business Address: _____

Home Phone: _____ Business Phone: _____ Fax: _____

Cell Phone: _____ Pager: _____ Email: _____

Marital Status: S D M: Spouse Name (if applicable): _____

School Graduated: _____ Degree Attained: _____ Year: _____

State(s) or Country(ies) in which you are licensed to practice: _____

Specialty(ies) _____ Subspecialty: _____

Internship (pl): _____ Yr: _____ Residency (pl): _____ Year: _____

Fellowship (pl): _____ Yr: _____

Specialty Board Eligible? Y N Certified? Y N Recertified? Y N Year: _____

Are you in private practice? Y N If yes, where? _____ How long? _____

Private Practice: Y N Retired: Y N

Other positions held, if not in private practice: _____

Hospital Affiliation(s): _____

Professional awards, honors or recognition received, or other special attainments? _____

What organizations do you belong to?: _____

Current medical license(s)? Y N State(s): _____

Medical License(s) #: _____ Expiration Date: _____

Medical practice insurance carrier: _____ Exp. Date _____

Has your license been suspended in the past 5 years? Y N Reason: _____

Names of two references:

Name: _____ Address: _____

Name: _____ Address: _____

Preference: Once a month Twice a month On call or in an emergency

Day or days: _____

Signature: _____

Date: _____

Please enclose copies of the following: 1) Current medical license 2) Diploma from medical school 3) Post graduate training certificate 4) Specialty board certificate – **if available**.



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ALOHA MEDICAL MISSION CLINIC-HONOLULU

MEMORANDUM OF UNDERSTANDING

I hereby volunteer my services at the Aloha Medical Mission Clinic (AMM)-Honolulu, a free clinic providing treatment to those with no health insurance or financial means of paying for health care in Hawaii as of this day

_____.

I understand that the Aloha Medical Mission serves as the coordinating organization for this Clinic.

I understand that no volunteer is paid for any services rendered to the patients, and that volunteers involved in the Clinic do not receive any remuneration for work performed in connection with the free clinic.

I understand that all medical records for any of the patients I treat will be securely maintained at the AMM Clinic-Honolulu in accordance to HIPAA requirements. I understand that I may bring my own medical and surgical instruments, and any other equipment and supplies I may need to render medical or dental services to patients at the Clinic.

I understand that I am obliged to adhere to Aloha Medical Mission's Volunteer Code of Conduct, attached to this Memorandum, and to abide by it during my participation at the Clinic.

I further understand that my work with the Mission shall not in any way be used for advertising, marketing or any other commercial purpose without prior approval and express written consent of the Board of Directors of the Aloha Medical Mission.

Name (Please PRINT.)

Signature

Date



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Informed Refusal for Hepatitis B Vaccination

I, _____ am employed by/volunteer as a health care practitioner at *Aloha Medical Mission Honolulu Clinic*. I am aware and understand the effectiveness of Hepatitis B immunization, the risk of contracting Hepatitis B, and the importance of taking active prevention to reduce the risk.

However, I, of my own free will and volition, and despite the Clinic's urging, have elected not to be vaccinated against Hepatitis B. I have personal reasons for making the decision not to be vaccinated.

Employee/Volunteer Signature

Date

Printed Name

Address

Witness Signature

Confidential