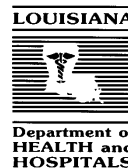




STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS



AGREEMENT TO PROVIDE VOLUNTEER SERVICES FOR LOUISIANA RESIDENTS

This agreement is between the State of Louisiana through the Department of Health and Hospitals (hereafter referred to as "DHH") and _____ (hereafter referred to as "Volunteer").
(PRINT NAME CLEARLY)

Volunteer agrees to provide services to the State of Louisiana through DHH. The Volunteer agrees and understands that he/she will not receive monetary compensation for his/her services for disaster response.

DHH agrees to accept the services of volunteer without monetary compensation being paid to volunteer.

DHH and volunteer agree that volunteer to the extent allowed by law is an employee of DHH for the limited purposes of indemnification, immunity, and worker's compensation medical (but not weekly disability payments) benefits for any actions that may arise in the course and scope of volunteer's assigned duties.

DHH and volunteer further agree that the volunteer's service may be immediately terminated by DHH or volunteer.

If the volunteer is providing services within their given discipline and scope of practice, by signing this agreement, the volunteer verifies that s/he has current credentials and/or professional licenses for which credit has been claimed. **The site address, dates of service and services to be provided are:**

Site Address:

St. Anna's Mobile Medical Mission
1313 Esplanade Ave.
New Orleans, LA 70116

Lower 9th Ward Clinic
5228 St. Claude Ave.
New Orleans, LA 70117

Dates of Service : From: ____/____/200__ To: ____/____/200__

Services To Be Provided: (Please Circle One) Medical Services Nursing Services

Description of Services:

_____ Screening, assessment, counseling, treatment, simple procedures and referral of persons seeking medical care (mental or physical health) as allowed by training and licensure of staff

Profile of Volunteer: The following information shall be provided with this signed agreement.

Validated Credentials and Level Classifications	Physicians	Registered Nurses	Behavioral Health Personnel
Level 1			
Degree	Required	Required*	Required
Unencumbered License	Required	Required	Required
Certification/ Specialization	Required	Required	Required
Active Clinical Practice/ Privileges	Required	Required	Required
Disaster Training	Preferred	Preferred	Preferred
Level 2			
Degree/ Diploma	Required	Required*	Required
Unencumbered License	Required	Required	Required
Certification/ Specialization	Required	Required	Required
Disaster Training	Preferred	Preferred	Preferred
Level 3			
Degree/ Diploma	Required	Required*	Required
Unencumbered License	Required	Required	Required
Specialization (Non-certified)	Not applicable	Required if applicable	Not applicable
Disaster Training	Preferred	Preferred	Preferred
Level 4			
Occupation	Required	Required	Required
Professional School and Year (X of Y)	Required	Required	Required if applicable
Disaster Training	Preferred	Preferred	Preferred
Secondary Validation (All Levels)			
National Practitioner Databank Status	Required	Not applicable	Not applicable
DEA License Verification	Required	Not applicable	Not applicable
Inspector General Status**	Required	Not applicable	Not applicable

Definitions:

Degree/ Diploma - relative amount of degree or intensity of competence of a given discipline or given course of study; determined by accredited agency and/or organization which identifies the given level of competency to be attained/ maintained.

Unencumbered License – latitude of action and restraints granted by an authorized body to practice a specified profession.

Certification/ Specialization – fulfillment of specified requirements that evidence knowledge over certain process or program.

Active Clinical Practice/Privileges -specific right granted to certain providers to admit patients to a hospital(s).

Disaster Training – any type of training received within the past two years geared towards disaster response.

VOLUNTEER:

Signature: _____

Print name: _____

Date: _____

DHH REPRESENTATIVE:

Signature: _____

Print name: _____

Date: _____

Louisiana State Board of Nursing

17373 Perkins Road, Baton Rouge, LA 70810
Telephone: (225) 755-7500 Fax: (225) 755-7581 or (225) 612-7005

www.lsbn.state.la.us

Disaster Permit Affidavit

Please fax to (225) 755-7581 or (225)612-7005 if primary number is down, with copy of valid Driver's License and proof of current licensure in another state. Upon receipt of fax transmission, practice is authorized unless otherwise notified. Verification of processed affidavit is available on LSBN website: lsbn.state.la.us.

I. CURRENT INFORMATION

Applicant Name: _____ SSN: _____

Driver's License #: _____ State: _____

Date of Birth: ____ / ____ / ____ Cell Phone #: _____ Alternate #: _____

State of Licensure: _____ License No: _____ Profession: _____ RN _____ APRN

Louisiana Address (if available): _____

Permanent Address: _____

Site and Duration of Practice of Louisiana:

Hospital or Agency/ Site: St. Anna's Medical Mission

Hospital Contact Name and Phone #: Diana Meyers, 504-947-2121

Anticipated Duration: _____

II. COMPLIANCE QUESTIONS

YES ___ 1. Been arrested, charged with, convicted of pled guilty or no contest to, or been sentenced for any criminal offense, including all misdemeanors and felonies in any state/county?

YES ___ 2. Had a license to practice nursing or to practice as another health care provider denied, revoked, suspended, sanctioned, or otherwise restricted, or is any disciplinary action pending in any state (including Louisiana), country or jurisdiction? Have you had other than an honorable discharge from the military?

YES ___ 3. Been named in a civil/malpractice case relating to your employment as a nurse? Have you been reported to the National Practitioner Data Bank? Have you had clinical privileges suspended, revoked or limited?

YES ___ 4. Have a physical, mental or emotional condition that might affect your ability to practice safely as a registered nurse?

I, _____ affirm that I am the person referred to in this application for disaster permit as a Registered Nurse in the State of Louisiana; that the statements herein contained are true in every respect; that I have complied with all requirements of the law; and that I have read and understand this affidavit. Falsification of any information contained in this application may result in denial of disaster permit and/or board disciplinary action.

NOTE: Attach copy of picture identification and proof of licensure in another state.

Applicant Signature: _____ Date: _____

Form Date: 8/28/08