Chattanooga-Hamilton County Health Department

Office of Emergency Preparedness and Planning
921 East Third Street, Chattanooga, TN 37403-2165
Phone (423) 209-8068; Fax (423) 209-8069

PHYSICAN VOLUNTEER REGISTRATION FORM

Name: _____ _____ _____ _____ _____
First Middle Last Suffix Degree

Date of Birth: _____ **Specialty:** _____

National Provider ID Number: _____

Practice/Business Name: _____

Address: _____
Street

_____
City State Zip

Home Address: _____
Street

_____
City State Zip

Work Phone: _____ **Home Phone:** _____ **Cell Phone:** _____

Pager: _____ **Alternate Phone**: _____

Work email: _____ **Home email:** _____

Languages, other than English, (including sign language) that you speak and/or read:

_____

Medical License	Type	Number	Date Issued	Date Expires
State of Tennessee	_____	_____	_____	_____
Other State: (____)	_____	_____	_____	_____

DEA Number: _____ **Date Issued**: _____ **Date Expires**: _____

Do you have a current credentialing file at TPQVO? Yes ◯ No ◯

Are you currently on staff at a local hospital? Yes ◯ No ◯

Name of Hospital	Category	Specialty
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you actively practicing in your specialty? Yes ◯ No ◯

If not practicing, what is your current status (retired, administration, etc.)

_____ **Since When?** _____

Do you have any special training (chemical, radiological, etc.) that may be helpful?

_____

I hereby certify that all the information shown on this form is true, complete and accurate to my knowledge. I agree to operate in good mind and faith; within the scope of my training and experience and in the best interest of patients. I understand that I am applying to volunteer and that this is not an application for, or contract of, employment or payment for my services. I understand that every attempt will be made to reduce the risks to volunteers, however, some risks may be present during an emergency and I agree to assume my own risk as a volunteer. I agree, consent, and release from liability TPQVO, the Chattanooga Hamilton County Medical Society, individuals and institutions, and the Physician Volunteer Program for their acts performed in good faith and without malice in connection with collecting, investigating and releasing my demographic and credentialing information.

Signature: _____ **Date:** _____

Submit by Email **Reset Form**