



Paddle to Swinomish Tribal Journey 2011

MEDICAL SERVICE VOLUNTEER COVERSHEET

Please complete this form, attach requested documents, and submit to:

Alicia Engstrom, Legal Assistant
Office of Tribal Attorney
Swinomish Indian Tribal Community
11404 Moorage Way
La Conner, WA 98257

Name _____ Occupation: _____

State(s) Licensed/Registered _____ Specialty(ies) _____

Address _____ City, State, Zip _____

Telephone _____ Email address _____

Employer name & address _____

Please attach a copy of your license(s)/registration(s).

I am engaged in the private practice of medicine.

I ___do ___do not have medical malpractice insurance providing coverage of my volunteer medical services.

Malpractice Insurance Carrier _____ Policy # _____

Please attach the declarations page for your malpractice policy.

I am an employee of the United States government.

I am an employee of a Tribal government that has a compact or contract with the United States Indian Health Service to provide health care to Native Americans.

Other. Specify the nature of your employment: _____

I agree to promptly inform you of any changes in my employment, licensure/registration or insurance coverage.

Volunteer Applicant Signature _____ Printed Name _____ Date _____

FOR OFFICE USE ONLY

- Copy of License(s)/Registration(s)
- Proof of Malpractice Insurance (if applicable)

Application for Volunteer Work Approved on _____
(date)

Printed Name _____

Signature _____

Date _____

