Volunteers in Medicine
FREE CARE FOR THE UNINSURED
www.vimsj.org

423 N Route 9
Cape May Court House, NJ 08210
609-463-2846 · info@vimsj.org

Volunteer Primary Care Providers
Harry Chaikin, MD
Maria J. Jiminez Cerna, MD
Mary Ann Haflin, MD
D. Lynn Helmer, MD
William Hooper, MD
Gina Kremer, APN
Andrew Sitkoff, DO
Angelo Sparagna, MD
Demetra Zalman, APN

Volunteer Specialty Care Providers
Martin Carey, DPM
Jong Choi, MD
Sallustio Del Re, MD
Eliot Kaplan, MD
John Middleton, MD
Lawrence J. Naame, MD
Melind Pandya, DO
David Roeltgen, MD
Greg Speed, LCSW
Birenda Tandan, MD

Community Partners:
Cape Regional Medical Center
CMC Depart of Health
NJ Commission for the Blind
Rainbow Pediatrics
Reef Family Pharmacy

Dear Applicant,

Thank you for your interest in Volunteers in Medicine. As we discussed, malpractice coverage is provided via the Federal Tort Claims Act. Prior to beginning your service with Volunteers in Medicine you must complete our credentialing process and be approved by our Clinical Administrative Team. The credentialing process involves evaluating a practitioner's eligibility and competency for clinical privileges. Our credentialing policy applies to physicians, mid-level providers, and any licensed independent healthcare practitioner who provides services for Volunteers in Medicine. All qualified applicants will receive an application for medical staff membership and/or clinical privileges. We will make every effort to process your application in a timely and efficient manner and assist you in any way possible.

If, at any time, you have questions, please call or email Cathy, Jackie or me or set up a meeting to come to Volunteers in Medicine and discuss your paperwork. Our goal is to assist you to get on staff quickly while ensuring that we are compliant with state and federal guidelines.

Email completed applications to: credentialing@vimsj.org
Fax to: 856-896-0741
Or Mail to:
Volunteers in Medicine
Attn: Credentialing
423 North Route 9
Cape May Court House, NJ 08210

Sincerely,

Lynn Helmer, MD, FACP, MBA
Medical Director

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CREDENTIALING APPLICATION

Please type or print responses legibly and in ink. Please complete the form in its entirety and attach all required documentation.

Documents that must be completed and submitted include the following:

- ☐ Demographic Information
- ☐ Clinician Questionnaire
- ☐ Core Privileges Request
- ☐ Peer Reference Authorization Forms (we require two references)
- ☐ Policy declarations page or letter from current insurer, and list of all liability insurers and account numbers for past 10 years AND Authorization to Release Coverage Verification/Claims History
- ☐ Volunteer Attestation
- ☐ Hep B Consent/Waiver
- ☐ Hospital Affiliation Request Letter, if applicable
- ☐ Agreement for Medical Services

Please also submit the following with your application:

- ☐ Curriculum vitae (CV)-which includes all education and dates, hospital affiliations, and work and volunteer history.
- ☐ Copy of medical/professional license registration certificate
- ☐ Copy of medical board certification
- ☐ Other certificates (BLS, ACLS, ATLS, PALS, APLS) if available (not required)
- ☐ Current Drug Enforcement Administration (DEA) registration if available (not required)
- ☐ Current Controlled Dangerous Substances (CDS) registration if available (not required)
- ☐ Copies of diplomas (medical/professional school, residency, fellowship)-or release form for educational records
- ☐ Copy of government-issued picture identification

Demographic Information

Applicant Name: _____

Address/City/State/Zip:_____

Phone: _____ Date of Birth: ____/____/____

Email: _____ Gender:__ Male __Female

SS#:_____ NPI #:_____

Emergency Contact (name, relationship, phone)

_____

Demographic Information for _____

Professional/Licensure Information

Primary Practice Specialty:_____Board Certified? _Yes __ No Certificate Number:_____Year Certified:_____Expires:_____
Secondary Practice Specialty:_____ Board Certified? __ Yes__ No Certificate Number:_____Year Certified:_____Expires:_____
If not board certified, are you board eligible? __Yes __ No Application Date:

License Number	**Date issued**	**Expiration date**	
NJ Medical License			
NJ CDS – if available, not required			
DEA – if available, not required			
Have you ever been licensed in any other State? Please list all:			
State and License #	Date issued	Exp. date	Still active?

	Yes	**No**
Have you ever practiced under another name? If yes, what name?		
Do you currently provide healthcare services outside of New Jersey? (where?)		

Other Certifications (BLS, ACLS, ATLS, PALS, APLS) – not required

Certification	Date Issued	Expiration Date

Other Information

Do you speak any language other the English? If so, which language(s)?
Do you require any additional equipment or staff? (e.g. EKG tech, special table, or supplies)
How many 4 hour shifts per month can you volunteer?
What day of the week is best for you? __ Mon __ Tues __ Wed __Thurs __ Any ___Morning (9-12) ___Afternoon (1-5) ___Evening (4-8)

Insurance

Please attach proof of professional liability insurance, such as a policy declarations page or letter from insurer, and list all insurance carriers for the past 10 years

Name of Insurance Carrier:_____Dates of Coverage:_____

Policy Number: _____

Name of Previous Carrier(s):_____Dates of Coverage:_____

Policy Number: _____

Name of Previous Carrier(s):_____Dates of Coverage:_____

Policy Number: _____

YES answers should be explained on a second sheet.		
Disciplinary Information	**Yes**	**No**
Have your clinical privileges ever been revoked, restricted, or suspended?		
Has your membership on any medical staff ever been revoked, restricted, or suspended?		
Has your DEA license ever been denied or suspended?		
Have you ever been excluded from participation with Medicare or Medicaid program?		
Have you ever been requested to appear before a licensing agency (State Board of Examiner's, Drug Enforcement Agency) for any reason?		
Have you ever been sanctioned by a federal or state agency?		
Have you ever discontinued your practice (other than for vacation, education/training, maternity leave, or leave due to illness) for three months or more?		
Insurance		
Has an insurance carrier denied, cancelled, or refused to renew your insurance coverage?		
Have you ever had any professional liability claims brought against you*? If YES, please complete "Professional Liability Claims History Form" or attach detailed report including relevant information about all claims in the past 10 years, including plaintiff and patient, month/year of occurrence, month/year of claim, insurance carrier, your involvement as primary defendant or co-defendant, and your clinical role, patient outcome, current status of suit, judgement amount.*		

Attestations (please initial each statement and sign below)

1.	I attest that I am in good health and have no health related or other conditions that may affect my ability to perform clinical or professional duties.	
2.	I agree as evidenced by my signature that the information provided in this application is true and complete to the best of my knowledge and that the omission or falsification of information may be cause of ineligibility or termination from medical staff membership.	
3.	I attest that I have received, read, and had the opportunity to ask questions about the Federal Tort Claims Act Coverage of Free Clinic Health Care Professionals. Copy available in each office or at https://bphc.hrsa.gov/ftca/freeclinics/pdf/pin1102.pdf	

	☐ I understand that this FTCA policy will cover me only for the work I do at Volunteers in Medicine and that I may not use VIM programs or prescriptions for non-VIM patients. ☐ I decline coverage through FTCA and will supply proof of coverage through a separate policy.	
4	I have obtained and/or attended the required number of continuing medical education hours necessary to maintain my New Jersey license and the majority of the CME hours relate to the clinical privileges I am requesting. I agree and will be able to provide proof of attendance and program content upon request.	
5	I specifically authorize Volunteers in Medicine and its authorized representatives to consult with any third party who may have information, including otherwise privileged information, bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter bearing on my satisfaction of the criteria for VIM Medical Staff appointment as well as to inspect any and all communications, reports, statements, documents, recommendations, or disclosures of said third parties relating to such questions. I also specifically authorize said third parties to release such information, including any and all peer review material from any and all hospitals wherein I have held appointments, to VIM and its authorized representatives upon request.	

_____

Applicant Signature Date

_____

Print Name

CORE PRIVILEGES *for* _____

Core Privileges	Approved	Pending	Denied
Primary Care: • Outpatient primary care for adults aged 18 and up, including history and physical examinations. • Management of acute and chronic conditions typically seen in primary care, including prescribing of medications, ordering of diagnostic tests, referral to and communication with specialists. • Prevention, health maintenance, and education of patients about healthy lifestyle choices.			
Specialist: • Outpatient consultation and management of patients with symptoms or diagnoses pertaining to the specialty of _____. • History and physical examinations, and management of acute and chronic conditions typically seen in the above specialty, including prescribing of medications, ordering of diagnostic tests, referral to and communication with other specialists and primary care team. • Prevention, health maintenance, and education of patients about healthy lifestyle choices as applicable.			
List Additional Procedures and attach a certification of training and competency if indicated			

Applicant's Signature/Date: _____

Medical Director Signature/Date: _____

Peer Reference

References

Please list two professional references who can attest to your qualifications, clinical and professional competence, and character. At least one reference must be a NJ licensed physician.

Name:_____

Title:_____ Institution:_____

Relationship to Candidate:_____

Address:_____

_____

Phone:_____Fax:_____

Email:_____

Name:_____

Title:_____ Institution:_____

Relationship to Candidate:_____

Address:_____

_____

Phone:_____Fax:_____

Email:_____

For each reference, please complete the "Applicant Peer Request Form" and return to Volunteers in Medicine. VIM will forward to each contact.

Volunteers in Medicine
FREE CLINICS OF SOUTH JERSEY
www.vimsj.org • 609-463-2846

APPLICANT PEER REFERENCE FORM

To: Date:

Name of Applicant:

I have submitted an application for appointment/reappointment to the staff of Volunteers in Medicine in the specialty listed below. Please complete the information on the attached form and return it directly to:

Email completed applications to: credentialing@vimsj.org

Fax to: 856-896-0741.

Or Mail to:
Volunteers in Medicine
Attn: Credentialing
423 North Route 9
Cape May Court House, NJ 08210

My signature authorizes you to complete the form at my request.

Thank you.

Sincerely,

_____
Signature/Date

☐ PRIMARY CARE:

- Outpatient primary care for adults age 18 and up, including history and physical examinations;
- Management of acute and chronic conditions typically seen in primary care, including prescribing of medications, ordering of diagnostic tests, referral to and communication with specialists.
- Prevention, health maintenance, and education of patient about healthy lifestyle choices.

☐ SPECIALIST:

- Outpatient consultation and management of patients with symptoms or diagnoses pertaining to the specialty of _____.
- History and physical examinations, and management of acute and chronic conditions typically seen in the above specialty, including prescribing of medications, ordering of diagnostic tests, referral to and communication with other specialists and primary care team.
- Prevention, health maintenance, and education of patient about healthy lifestyle choices as applicable.

Peer Reference for Name:

	Yes	No
Does the applicant demonstrate current clinical competence and provide appropriate care to patients?		
Does the applicant demonstrate good diagnostic capabilities and good technical skills in the performance of invasive procedures, if applicable?		
Does the applicant demonstrate effective communication skills with patients, families, and others involved in their care?		
Have you observed or been informed of any health related or other conditions related to this applicant that has or reasonably may affect his or her ability to perform professional duties?		
Does the applicant maintain timely documentation of history and physical exams, progress notes, operative notes, narrative summaries, etc.?		
Does the applicant exhibit personal integrity and adherence to professional ethics?		
Does the applicant work well with others, communicate well and timely with other providers, and have a good rapport with patients?		
What is your opinion regarding competency in performing the attached privileges?		
Are you aware of the practitioner being subjected to any disciplinary action by any licensing or certifying board or any healthcare facility regarding medical staff membership and/or clinic privilege?		

The above evaluation is based on (check all that apply):

__ Close observation of clinical performance
__ Composite information from file
__ Co-worker
__ General Impression
__ Practitioner's reputation in the community

Recommendation:

__ Highly recommend without reservation
__ Recommend with reservation
__Recommend as qualified and competent
__ Do not recommend

Name	Title
Institution	Date
Signature	

Return Form to: Volunteers in Medicine, 423 North Route 9, Cape May Court House NJ 08210
Fax: 856-896-0741 or Email: credentialing@vimsj.org

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Volunteer Attestation

Flu: Have you had your annual flu vaccine? ___Yes ___ No

Covid: Are you up to date with Covid vaccines as defined for you by the CDC? ___Yes ___ No

Hep B: As a clinical volunteer having potential exposure to infectious materials, you have the right to receive the Hepatitis B vaccination series. Have you had the Hepatitis B vaccine? ___Yes ___ No
If No, please speak with the Clinic Director. Licensed volunteers will be required to complete additional paperwork.

TB Screening: TB (tuberculosis) screening is required for all volunteers prior to commencement of duties. Please complete the information below.

Have you ever been tested for TB? ___Yes ___ No

- If No, speak with the Clinic Director to arrange a test
- If Yes, have you ever had a positive result? ___Yes ___ No
    - If yes, please discuss circumstances/next steps with Clinic Director
- If no, when and where was your last negative test?

  _____
- Have you been in an area that is considered high risk for TB since your last test? ___Yes ___ No (If yes, we will arrange a follow-up test)

General: Do you have any medical conditions of any kind or any other circumstances that would interfere with your ability to do the work required by your desired VIM volunteer position safely and effectively?
___Yes ___ No

Misc. Have you ever been convicted of a felony or misdemeanor other than a minor traffic offense?
___Yes ___ No

CONFIDENTIALITY STATEMENT: I understand and agree that in the performance of my duties as a volunteer/employee at Volunteers in Medicine I must keep all patient information strictly confidential and adhere to all HIPAA regulations. I understand that any violation of the confidentiality of this information will not be tolerated.

I agree as evidenced by my signature that the information provided in this application is true and complete to the best of my knowledge.

_____
Applicant Signature Date

_____
Print Name

Volunteers in Medicine

Volunteer Name _____ Date _____

Hepatitis B Consent/ Waiver

As a clinical volunteer having potential exposure to infectious materials, you will have the right to receive the Hepatitis B vaccination series, free of cost to you. Please read the Hepatitis B Vaccination information sheet and complete this form by checking the box preceding the appropriate statement and signing, dating and indicating your DOB at the bottom. Thank you!

❑ **CONSENT:** As a clinical volunteer having occupational exposure to blood or other potential infectious materials, which includes the risk of acquiring Hepatitis B virus (HBV) infection, I have been informed about and offered the opportunity to receive the Hepatitis B vaccine (to be paid for by Volunteers in Medicine). I understand that I must have 3 doses of vaccine to develop immunity. However, as with any medical treatment, there is no guarantee that I will become immune or that I will not experience any adverse side effect from the vaccine. I accept the offer at this time.

❑ **DECLINATION:** I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline Hepatitis B vaccination at this time. I know this continues to put me at risk, but if in the future, while actively working with the Volunteers in Medicine, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive it at no charge to me.

I am declining the opportunity to receive the Hepatitis B vaccination series for the following reason: **(please check one)**

- ☐ I have previously received the complete Hepatitis B vaccination series. Date _____
- ☐ Antibody testing has revealed I am immune to Hepatitis B. (Please submit laboratory numerical proof of immunity.)
- ☐ The vaccine is contraindicated for medical reason(s): (Please describe)
- ☐ Other:

Signature:_____ **Date:** _____

Print Name:_____ **DOB:** _____

AUTHORIZATION TO RELEASE COVERAGE VERIFICATION/CLAIMS HISTORY

(required regardless of claim history)

Requesting information from

Insurance Company Name:
Address
Phone
Fax
Email

I hereby authorize the insurance company listed above to release my claim/coverage history to Volunteers in Medicine. Please send report to:

Volunteers in Medicine
Attn: Credentialing, 423 N Route 9, Cape May Court House, NJ 08210
Phone: 609-463-2846 · Fax: 856-896-0741 · Email: credentialing@vimsj.org

Practitioner's Signature: _____

Signature Date: _____

Practitioner's full name:	
Current phone	
Current mailing address:	
Policy #	Medical license #
NPI	

PROFESSIONAL LIABILITY CLAIM HISTORY FORM

The following is necessary to complete the credentialing verification process and will be kept confidential. This professional liability claim information form is required on all claims/lawsuits that are reported by your professional liability insurance carrier and/or the National Practitioner Data Bank in the past 10 years. Clinical details are required for all suits, regardless of status or settlement amount. Please provide information for any professional liability claims and lawsuits reported to your professional liability insurance carrier, open or closed, settled or paid. Include only one case per sheet; copy this form if needed for more than one case.

Plaintiff	Month/year of lawsuit or claim
Patient Name:	Patient Date of Birth
Month and year of occurrence/event	Insurance carrier for this claim

What is/was your status: ☐ Primary defendant ☐ Co-defendant ☐ Other

Explain and list other defendants

Summary of the allegations against you

What was your clinical role with regard to the patient?

What was the patient's outcome?

Current Status of Claim:

☐Dismissed Date:_____ ☐Defense Verdict Date:_____ ☐Still Pending

☐Settled Date:_____ ☐ Plaintiff Verdict Date:_____

Judgment/Settlement Amount $:_____ Amount paid on your behalf $_____

I certify that the information contained in this form is correct and complete to the best of my knowledge.

Applicant Signature Date

Medical Director Review of claim(s), recommendations/risk management plan (if indicated):

_____ _____

Applicant's Signature Date Medical Director Signature Date

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www.vimsj.org

Hospital Affiliation

Provider Name:

Specialty:

Name of institution:

To Whom It May Concern:

I have submitted an application for appointment/reappointment to the staff of Volunteers in Medicine. Please complete the information requested below and on the attached page and return it directly to the address below. My signature authorizes you to complete the form at my request. Thank you for your prompt attention to this request.

Sincerely,

_____

Signature Date

Current status (please attach copy of privileges) _____

Membership from _____(Date) to _____(Date)

Return Form to: Fax: 856-896-0741 or Email: credentialing@vimsj.org
Mail: Volunteers in Medicine, Attn: Credentialing, 423 N Route 9, Cape May Court House NJ 08210

Hospital Affiliation for _____

If appropriate, please provide additional details below or on a separate sheet.	**Yes**	**No**	**N/A**
Does the applicant demonstrate current clinical competence and provide appropriate care to patients?			
Does the applicant demonstrate good diagnostic capabilities and good technical skills in the performance of invasive procedures, if applicable?			
Does the applicant demonstrate effective communication skills with patients, families, and others involved in their care?			
Have you observed or been informed of any health related or other conditions related to this applicant that has or reasonably may affect his or her ability to perform professional duties?			
Does the applicant maintain timely documentation of history and physical exams, progress notes, operative notes, narrative summaries, etc.?			
Does the applicant work well with others, communicate well and timely with other providers, and have a good rapport with patients?			
Does the applicant exhibit personal integrity and adherence to professional ethics?			
Is the practitioner compliant with organizational policies and medical staff bylaws?			
Has the practitioner been involved in a malpractice claim or lawsuit since the last appointment or reappointment?			
At the appropriate time, will you likely reappoint the practitioner to your medical staff?			

Verification provided by:

Name	Title
Signature	Date
Institution	

Return Form to: Fax: 856-896-0741 or Email: credentialing@vimsj.org
Mail: Volunteers in Medicine, Attn: Credentialing, 423 N Route 9, Cape May Court House NJ 08210

AGREEMENT FOR VOLUNTEER MEDICAL SERVICES

THIS AGREEMENT FOR VOLUNTEER MEDICAL SERVICES ("Agreement") is made as of the _____ day of _____, 202_, by and between VOLUNTEERS IN MEDICINE PHYSICIAN GROUP, P.C., a professional corporation organized under the laws of the State of New Jersey (hereinafter called the "Physician Group") and _____, a medical provider, (physician, nurse practitioner, or physician assistant), licensed to practice medicine in the State of New Jersey (hereinafter called the "Provider"), and Cape Volunteers in Medicine, a New Jersey nonprofit corporation (hereinafter called "VIM").

The Parties to this Agreement, in consideration for the mutual covenants herein contained and intending to be legally bound hereby, agree as follows:

1. The Provider shall provide free medical services (the "Clinical Services") at a facility operated by the Physician Group and subsidized by VIM (the "Facility"). The Provider shall not submit a bill for the Clinical Services to any individual or entity. The Provider shall not receive any compensation or remuneration of any kind in exchange for providing the Clinical Services.

2. The Provider shall remain licensed to practice medicine in the State of New Jersey during the term of this Agreement.

3. The Provider shall comply with all applicable Federal and State laws, rules, and regulations, as well as the bylaws, rules and regulations, policies, and directives of the Physician Group in the provision of the Clinical Services, including those set forth by the Culture of Caring in the VIM Mission.

4. The Provider shall be subject to the direction and oversight of the Physician Group's Medical Director in the provision of the Clinical Services and shall comply with all of the Medical Director's instructions in connection with the Clinical Services. The Medical Director shall at all times be a physician licensed to practice medicine in the State of New Jersey.

5. The Physician Group shall supply the Physician with all necessary supplies, materials, and equipment in connection with the provision of the Clinical Services.

6. VIM shall ensure professional liability insurance to cover the Clinical Services at no cost to the Provider.

7. This Agreement shall continue until terminated by either party, and may be terminated by either party in writing at any time without cause.

[SIGNATURES APPEAR ON FOLLOWING PAGE]

IN WITNESS WHEREOF, the parties have executed this Agreement as of the day and year first above written.

VOLUNTEERS IN MEDICINE PHYSICIAN GROUP, P.C., a New Jersey professional corporation

BY:_____
D Lynn Helmer, M.D., President

CAPE VOLUNTEERS IN MEDICINE, INC

BY:_____
Jacqueline Meiluta, Executive Director

PROVIDER

BY:_____