NEW MEXICO DEPARTMENT OF HEALTH

Volunteer Health Care Tort Coverage Program for Providers Application

Last Name: _____ First Name: _____ Initial_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (h) _____ (c) _____ (o) _____

Email: _____

Profession: _____ Specialty: _____

Lic. #: _____Exp: _____

DEA # _____ Exp.: _____

Please attach copies of all licensures with application:

Organization you would like to volunteer at:
(*Please list in order of preference)*

1. **_____**

   Contact Name: _____
   Address: _____
   Phone: _____

2. **_____**

   Contact Name: _____
   Address: _____
   Phone: _____

2. **_____**

   Contact Name: _____
   Address: _____
   Phone: _____

Has the organization been approved and registered for the Tort Coverage Program by the New Mexico Dept. of Health, Health Facility Licensing and Certification Bureau? ? Y N

Have you ever been convicted of a felony? Y N

Do you have liability insurance Coverage? Y N

Would you like to be added to the states emergency volunteer registry NMserves? Y N

Would you like more information on NMserves? Y N

I _____, authorize the Department of Health staff to conduct a criminal background check and/or to obtain my personal records as part of the background check.

Signature: _____ Date: _____