INSTRUCTION FOR COMPLETING THE INDIVIDUAL VOLUNTEER HEALTH CARE PROVIDER ("VHCPP") APPLCATION/PROTECTION AGREEMENT

As of December 2020, the Individual VHCPP application is available in an electronic format. While the paper version is still available, the electronic application is easy to complete and submit. Your use of this version is preferred. **Please Note**: The sections cited in these instructions apply to the electronic version of the application.

Use the link below to access the electronic form.

https://www.cognitoforms.com/IowaDepartmentOfPublicHealth1/IndividualVolunteerHealthCareProviderProgramVHCPPApplicationAndProtectionAgreement

If you use the paper version, please complete and send it via email (you'll need to scan it in order to send it via email) or hard copy to:

Becky Swift
IDPH
Lucas State Office Building, 4th Floor
321 E. 12th Street,
Des Moines, IA 50319
Rebecca.swift@idph.iowa.gov

Questions? Please call Becky Swift at 515-281-4344

SECTION 1 – GENERAL

Name. Enter your first and last names.

Address. Enter your mailing address.

Phone. Enter your preferred phone number, including the area code.

Email. Enter a valid email address. By providing us with your email address, you agree we may communicate with you by electronic mail. The VHCPP prefers to communicate with participants by electronic mail.

License. Enter your current professional license, certification, or registration number and the expiration date. Please enter all letters and zero's associated with your license number. Also note whether this is an initial (new) application or a renewal.

Identify your Profession. From the drop down box, select your profession. If you wish to apply under two different professions (e.g., nursing and EMT) you'll need to complete and submit a form for each.

Note: Below the Physician Assistant block a space is provided for a supervising physician's name and signature. The supervising physician must sign this space signifying they have agreed to supervise the PA.

SECTION 2 - PERSONAL HISTORY

Personal History. By signing the document you are providing a sworn statement attesting that your license, registration, or certification to practice is free of restrictions. **IF YOU HAVE HAD disciplinary action or a malpractice suit,** fields will open to allow you to provide the required information. **IF** you are using a paper application and have had disciplinary action or a malpractice suit, please complete and return Attachment A with your application.

SECTIONS 3 - 14 - PROTECTION AGREEMENT PLEASE READ THESE SECTIONS THOROUGHLY

These sections contain the **Individual Volunteer Health Care Provider** protection agreement. They describe the defense and indemnification that will be provided in the case of legal action taken as a result of your participation in the VHCPP.

SECTION 15–SIGNATURE OF AGREEMENT

Your Signature is Required. You are not protected for volunteer services provided prior to the signing of the protection agreement by yourself and the Iowa Department of Public Health ("Department"). Once fully executed, this document serves, for five (5) years, as the protection agreement between you and the Department. A fully signed copy will be kept on file and sent to you via email, or by regular mail if requested.