



**FLORIDA DEPARTMENT OF HEALTH  
VOLUNTEER HEALTH SERVICES  
VOLUNTEER HEALTH CARE PROVIDER PROGRAM (VHCPP)  
NEW FLAGLER CLINIC**

**SOVEREIGN IMMUNITY CONTRACT APPLICATION**

Provider Name: \_\_\_\_\_  
(Last) (First) (Middle)

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Phone: \_\_\_\_\_  
(Area code)

Occupation: \_\_\_\_\_ Specialty: \_\_\_\_\_ FL License Number: \_\_\_\_\_

*It is recommended by the Department of Health that individual providers, applying for a VHCPP contract for sovereign immunity protection, and who are affiliated with a Professional Association, (P.A.)/Group, also establish a Sovereign Immunity contract to protect the P.A./Group and its employees. Please indicate if you would like a contract for the P.A./Group you're affiliated with.*

**CHECK APPROPRIATE RESPONSE, SIGN AND DATE THE FORM**

Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_ PA currently contracted \_\_\_\_\_  
*(If Yes, please complete the following information)*

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*P A/Group Corporation Name:* \_\_\_\_\_

*Printed Name of Corporate Officer/Director with Contract Authority:* \_\_\_\_\_

*Business Address:* \_\_\_\_\_  
(Street) (City) (State) (Zip)

*Mailing Address ( if different from Street Address):* \_\_\_\_\_

*Phone Number:* ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ *FEI or Document Number:* \_\_\_\_\_  
(Area code)

**IN ORDER TO PROTECT CLIENTS A ROUTINE CHECK OF THE FLORIDA MEDICAL LICENSE AND CORPORATION NAME WILL BE MADE THROUGH THE FLORIDA DEPARTMENT OF HEALTH MEDICAL QUALITY ASSURANCE AND/OR THE FLORIDA DIVISION OF CORPORATIONS.**

**License/Corporation Verification (for DOH use only)**

Individual

Current Florida Health Professional License? Yes \_\_\_\_\_ No \_\_\_\_\_  
License Status "Clear and Active?" Yes \_\_\_\_\_ No \_\_\_\_\_

Corporation:

Active and Registered Florida Corporation? Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

Verification Completed By: \_\_\_\_\_  
(Signature of VHCPP Regional Coordinator) (Date)