REGISTRATION
SPONSORING ORGANIZATION OF CHARITABLE HEALTH CARE PROVIDERS

KRS 216.941
902 KAR 22:404

SPONSORING ORGANIZATION INFORMATION:

(Organization Name)

(Contact Name)

(Address)

(City, State, and Zip Code)

(Phone, Office)

(Email Address)

LIST ALL CHARITABLE HEALTH CARE PROVIDERS RENDERING MEDICAL/DENTAL CARE AT THE LOCATION OF THE SPONSORING ORGANIZATION: (attach additional sheets as necessary)

PROVIDER NAME

LICENSE NUMBER

ADDRESS

STATE/TERRITORY

PROVIDER NAME

LICENSE NUMBER

ADDRESS

STATE/TERRITORY

PROVIDER NAME

LICENSE NUMBER

ADDRESS

STATE/TERRITORY

PROVIDER NAME

LICENSE NUMBER

ADDRESS

STATE/TERRITORY

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STATE/TERRITORY

PROVIDER NAME

LICENSE NUMBER

ADDRESS

STATE/TERRITORY

PROVIDER NAME

LICENSE NUMBER

ADDRESS

STATE/TERRITORY

LIST ANY MEDICAL MALPRACTICE INSURANCE PROCURED UNDER SECTION 6 OF KRS 216. (ANY PROVIDER UNDER YOUR ORGANIZATION)

POLICY PERIOD:

POLICY NUMBER:

EXPECTED NUMBER OF RECIPIENTS (Patients) IN A 12 MONTH PERIOD:

LIST THE COUNTY (or counties, if applicable) IN WHICH THE CHARITABLE HEALTH CARE PROVIDERS WILL RENDER SERVICE.

WHO ARE THE INTENDED PATIENTS FOR THIS SPONSORING ORGANIZATION OF CHARITABLE HEALTH CARE PROVIDERS?

WHAT TYPE OF SERVICES WILL BE RENDERED BY THE HEALTH CARE PROVIDERS OF THIS SPONSORING ORGANIZATION? (Family Practice, Pediatrics, Internal Medicine, OB/GYN, Dental, other)

WHAT DATES WILL THE SERVICES BE PROVIDED TO THE INTENDED PATIENTS OF CHARITABLE HEALTH CARE? ((Examples: specific dates throughout the year, second Thursday of each month, weekly on Tuesdays and Fridays, Monday through Friday each week, etc.)

Required form to be completed and returned by the Sponsoring Organization

SPONSORING ORGANIZATION
NOTARIZED STATEMENT

AS REQUIRED BY KRS 216.941(2), ANY CHARITABLE HEALTH CARE PROVIDER WORKING WITHIN THE SPONSORING ORGANIZATION SHALL NOT ALLOW A:

(1) PERSON WHOSE LICENSE OR CERTIFICATE IS CURRENTLY SUSPENDED OR REVOKED UNDER DISCIPLINARY PROCEEDING IN ANY JURISDICATION, TO PARTICIPATE WITH THE SPONSORING ORGANIZATION.

(2) PERSON WHO RENDERS SERVICES OUTSIDE OF THE SCOPE OF PRACTICE AUTHORIZED BY HIS OR HER LICENSE OR CERTIFICATION OR EXCEPTION TO THE LICENSE OR CERTIFICATION ALLOWED PARTICIPATING WITH ANY SPONSORING ORGANIZATION.

I, _____, HEREBY ATTEST THAT AS THE REPRESENTATIVE FOR

_____

WE HAVE VARIFIED THROUGH A NOTARIZED STATEMENT, AFFIDAVIT, OR OTHER WRITTEN AND SIGNED STATEMENT FROM THE PROVIDER ATTESTING TO COMPLIANCE WITH KRS 216.941(2).

Sample notarized statement that may be used by a Sponsoring Organization to verify a provider's compliance with KRS 216.941(2).

NOTARIZED STATEMENT

I, _____ _____, HEREBY ATTEST THAT MY LICENSE OR CERTIFCATE IS NOT SUSPENDED OR REVOKED. ANY CHARITABLE HEALTH CARE PROVIDER WORKING WITHIN THE SPONSORING ORGANIZATION _____ SHALL NOT HAVE A CURRENT PROFESSIONAL LICENSE OR CERTIFICATE SUSPENDED OR REVOKED UNDER DISCIPLINARY PROCEEDINGS IN ANY JURISDICTION OR RENDERED SERVICES OUTSIDE THE SCOPE OF PRACTICE AUTHORIZED BY HIS OR HER LICENSURE OR CERTIFICATION.

NOTARY PUBLIC

My commission expires:

Sample affidavit statement that may be used by a Sponsoring Organization to verify a provider's compliance with KRS 216.941(2).

AFFADAVIT OF DR. EXAMPLE

Comes now E. Howard Example, M.D. and avers the following:

1) I am a Board Certified Physician and have X years experience as a physician.

2) I have a valid license in the State of Kentucky, license #123456.

3) I am in good standing by the Board of Licensure and I do not have a current license or certificate suspension determined by a disciplinary proceeding in any jurisdiction.

4) I only provide services as allowed by the scope of practice authorized by my license.

Further affiant saith not.

E. HOWARD EXAMPLE, M.D.

Sworn and subscribed before me this the ____ day of _____ , 20__

NOTARY PUBLIC

My commission expires: