AUTHORITY TO RELEASE INFORMATION

I hereby authorize the Medical Staff Services office at Upstate University Hospital to release the following information to Syracuse Community Health Center Inc., in order to of obtain a National Practitioner Databank Query for the purpose of granting emergency privileges.

This authorization, an original or conformed copy, shall be valid for 90 days from the date of signature.

Full Name ______________________________

Date: ______________________________

Other names used, if any ______________________________

Current Address: ______________________________

____

Date of Birth: ______________________________

Social Security Number: ______________________________

NPI: ______________________________

DEA Number: ______________________________

SIGNATURE: ______________________________ Date: ____________________

EMERGENCY VOLUNTEER/EMPLOYER ATTESTATION

LICENSED INDEPENDENT PRACITIONERS

Volunteer Name____Employer____

Licensure Type____License #____

Phone Number____E-mail____

The following documents are on file at the Employer identified above and are available upon request:

- Resume/CV
- License and Registration
- BLS Certificate ☐ Not Applicable
- Annual Health Assessment, including documentation of Immunizations as required by NY State DOH, including TB Screening and Influenza Vaccination

I attest that the documents identified above are verified, current and on file, and are available to SCHC upon request. I attest that the employee identified above is in good standing, fit for duty, and can perform the duties that are requested at the highest level of their licensure type as documented above.

Authorized Employer Representative:

____

Print Name **Signature**

____

Title **Phone Number** **Date**

I understand that SCHC will conduct a Primary Source Verification of my Licensure, including a search for professional misconduct, and a National Practitioner Data Bank Query. I attest that I adhere to all NYS licensing laws and requirements when performing services. I authorize my employer to release the documents identified above upon request by SCHC. I attest that I am free from impairment and can perform the duties requested, with or without reasonable accommodation. I will present my original Government Issued ID to SCHC, who will make a copy for their file. I will review and sign the SCHC HR Policy & Procedure 307 Confidential Data.

Volunteer:

____

Print Name **Signature** **Date**

If you have any questions, please call (315) 234-5960 and select Option 2, Option 3 or press 0.