



Dear Intern,

Thank you for considering interning at Urban Action Community Projects (UCAP) dba Health to Hope Clinics. (H2H)

H2H provides primary and preventative medical care to homeless individuals and families by operating three clinics inside emergency shelters and a mobile medical unit within Riverside County and became a HRSA 330 HCH grantee in 2012. In 2013 we provided more than 2,800 medical patient visits, nearly 2.5x the number of patient visits in 2011 (1,100).

UCAP is the only Federally Qualified Health Center (FQHC) indigenous to Riverside County specifically dedicated with a mission to help restore hope to the homeless through health wellness. We are also the only exclusive 300(h) grantee for all of Riverside County. UCAP began providing healthcare services through volunteer providers in 2009 as a community service project of Path of Life Ministries, the organization that runs the emergency and transitional shelters for the City of Riverside –hence the genesis of our name: Urban Community Action Project. Interns acted to provide medical care to those homeless and sleeping in the City's emergency shelter.

A separate 501c3 was established and today we operate three medical clinics for the homeless that are conveniently located inside emergency overnight shelters located in Riverside, Palm Springs and Indio and with a medical mobile unit in the City of Riverside. UCAP has used its grant funding to grow but it is the volunteers that sustain our mission to help and restore hope to the homeless through health wellness. We ask that our interns commit at least three months of service for four hours a week so that we know we are always maintaining the appropriate level of care. Experience is not necessary but a compassionate heart for others and a commitment to excellence are.



**Intern Applicant Information**

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First M.I.

Address: \_\_\_\_\_  
Street Address Apartment/Unit #  
City State ZIP Code

Phone: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Date Available: \_\_\_\_\_ Social Security No.: XXX-XX-XXXX (may be provided once accepted as a volunteer)

Are you a student? Major/Club \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Are you a citizen of the United States? YES NO YES NO  
    If no, are you authorized to work in the U.S.? YES NO

Have you ever worked for this company? \_\_\_\_\_ If so, when? \_\_\_\_\_

Have you ever been convicted of a felony? YES NO I am interning  Back Office  Front Office  
If yes, explain on separate sheet of paper   for  Both

Do you have a friend or relative working for the company? Y or N - If yes, please list \_\_\_\_\_

**Education**

High School: \_\_\_\_\_ Address: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Did you graduate? YES NO Degree: \_\_\_\_\_

College: \_\_\_\_\_ Address: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Did you graduate? YES NO Degree: \_\_\_\_\_

Other: \_\_\_\_\_ Address: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Did you graduate? YES NO Degree: \_\_\_\_\_

**References**

*Please list three professional references.  
Students list an instructor*

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Company: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Company: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_



Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Company: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

**Previous Employment**

Company: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Job Title: \_\_\_\_\_ Starting Salary: \$ \_\_\_\_\_ Ending Salary: \$ \_\_\_\_\_

Responsibilities: \_\_\_\_\_

From: \_\_\_ To: \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_

May we contact your previous supervisor for a reference? YES NO

Company: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Job Title: \_\_\_\_\_ Starting Salary: \$ \_\_\_\_\_ Ending Salary: \$ \_\_\_\_\_

Responsibilities: \_\_\_\_\_

From: \_\_\_ To: \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_

May we contact your previous supervisor for a reference? YES NO

Company: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Job Title: \_\_\_\_\_ Starting Salary: \$ \_\_\_\_\_ Ending Salary: \$ \_\_\_\_\_

Responsibilities: \_\_\_\_\_

From: \_\_\_ To: \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_

**Claim/Lawsuit History – 10 Year History**

If you answer yes to any of the following questions, please provide details per the attached claims information sheet. Please explain any surcharge to your professional liability coverage on a separate sheet.

Have you ever been a defendant in a malpractice suit?  Yes  No

Have any judgments been made against you or settlements been agreed to in any professional liability case?  
 Yes  No

Are there any professional liability lawsuits pending against you at the present time?  Yes  No



Has your professional liability insurance ever been terminated or restricted or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance?  Yes  No

### Health Status

If the answer to any question is “yes”, reference the question on a separate sheet. Please provide a full explanation and attach.

Are you currently using any chemical substance(s), which in any way may impair or limit your ability to practice medicine with reasonable skill and safety?  Yes  No

Are you currently engaged in the illegal use of controlled substances?  Yes  No

Do you have a mental or physical condition, which in any way may impair or limit your ability to practice medicine with reasonable skill and safety with or without reasonable accommodation?  Yes  No

### Professional Practice

Have any of the following been or are currently in the process of being denied, revoked, not renewed, suspended, limited, restricted, reviewed, placed on probation, or placed under the disciplinary action, either voluntarily or involuntarily in this or any other state, territory or country? If “yes”, provide full explanation and attach.

Medical or professional license?  Yes  No

DEA Registration or Controlled Substance License?  Yes  No

Hospital medical staff membership?  Yes  No

Clinical privileges or other rights on any hospital medical staff?  Yes  No

Employment by any hospital, institution or the military?  Yes  No

Professional society membership?  Yes  No

Participation in any private, federal, or state health insurance program (i.e. Medicare, CHAMPUS, Medicaid)  Yes  No

Participation in an HMO, PPO, or any other managed care organization?  Yes  No

Board Certification?  Yes  No

### Other Disclosures

At any time have you ever been:

Convicted of any criminal offense in any jurisdiction?  Yes  No

Convicted of a misdemeanor relating to a health profession, or received probation without a verdict, disposition in lieu of trial, or an accelerated rehabilitation of felony charges in any state, territory or country?  Yes  No

### Have you ever, at any time, or are you currently:

Under audit by a Health Care Agency (i.e. Medicare, Medicaid, MDCH, or any insurance)  Yes  No

Under indictment for crime?  Yes  No

The subject of an investigation by any private, federal, or state health insurance program or state, territory or country licensing board?  Yes  No



The subject of any adverse action reports to a state or federal agency?  Yes  No

Sanctioned by a government program for any reason?  Yes  No

**Have you ever, at any time, either voluntarily or involuntarily:**

Withdrawn your application for medical staff membership at any facility?  Yes  No

Withdrawn your request for any clinical privileges at any facility?  Yes  No

**ORIGINAL ATTESTATION STATEMENT**

I agree to the counts thereof as evidenced by my signature that the information provided in this application is true by the best of my knowledge and that omissions or falsification of information may be cause for ineligibility or disaffiliation

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**CONSENT TO RELEASE OF INFORMATION FORM**

I understand that Urban Community Action Projects will verify statements made on my interning application and made during my interview. When contacted by this company, I give permission for my former employers and educational institutions to relate information or opinions about myself, in order that I may be evaluated for staffing purposes. I hereby release these persons and/or organizations as well as Urban Community Action Projects from any and all liability from damages of whatever kind or nature, whether known or unknown, which may at any time accrue to me on account of information obtained pursuant to this authorization.

Nature of Relationship: I understand that if I am approved to serve as an intern by Urban Community Action Projects, my interning can be terminated with or without cause, and with or without notice, at any time, at the option of either Urban Community Action Projects or myself. I understand that no employee, supervisor, manager, or officer of Urban Community Action Projects has any authority to enter into any agreement for interning for any specified period of time, or to make any agreement contrary to the foregoing, except the President/CEO of the Company can make such an agreement, but such an agreement would only be valid if it was made in writing and if it was signed by the President/CEO.

Certification of Accuracy Statement: I certify that all the statements I have made on this application and related papers and in interviews are true, and I understand any falsification, misrepresentations or intentional omission may be grounds for eliminating me from volunteering consideration, rescinding an employment offer or cause for dismissal without obligation on the part of Urban Community Action Projects, except for payment to me for any employment services already rendered.

Urban Community Action Projects will not discriminate against any employee or applicant for employment because of age (as defined by applicable law), religion, sex, race, color, national origin, or because they are disabled, a disabled veteran or Vietnam era veteran or on the basis of any other characteristic protected by federal, state, or local law. Answers to questions will be utilized for applicable, job-related information only.

I further affirm that I currently do not have any physical and/or mental conditions and/or impairments, such as substance abuse, alcohol dependency and/or mental health concerns which interfere with my ability to volunteer in this capacity

A photocopy of this consent shall be as effective as an original when presented.

Interns Applicant Printed Name: \_\_\_\_\_

Intern Applicant's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

