

MHAC Pro Bono Outreach Program Professional Volunteer Application

Please complete and return by mail or fax to MHAC.



I. PERSONAL INFORMATION

Name: _____ Date: _____

Mailing Address: _____

City/State/Zip: _____ Phone: _____

Cell Phone: _____ Work or alternate phone: _____

Fax: _____ E-mail: _____

Birthdate: Month: _____ Day: _____

Emergency contact:
Name: _____ Relationship to you: _____

Phone number: _____ Alternative phone number: _____

How did you hear about MHAC? _____

II. EDUCATION & EMPLOYMENT HISTORY *Please attach resume.*

Additional Information (Education, Special Training, Volunteer Experience, Memberships to Professional Organizations):

III. LICENSING AND CERTIFICATION INFORMATION *Please enclose copy.*

Licensed/Certified as: _____ State: _____

License/Certification #: _____ Expiration Date: _____

Licensed/Certified as: _____ State: _____

License/Certification #: _____ Expiration Date: _____

IV. PSYCHIATRIC BOARD CERTIFICATION *Please enclose copy.*

Certified by (Board): _____ Date: _____ Cert. # _____

Certified by (Board): _____ Date: _____ Cert. # _____

V. DRUG ENFORCEMENT ADMINISTRATION *(M.D./D.O./RxN/NP only. Please enclose copy.)*

Number: _____ Expiration Date: _____

VI. **PROFESSIONAL LIABILITY INSURANCE** Please enclose a COPY of proof of policy in force. Pro Bono volunteers must have their own liability insurance.

Agent/Carrier: _____ Policy #: _____

Amount of coverage per incident: _____ Aggregate Amount: _____

VII. **PEER RECOMMENDATIONS**

Name: _____ Mailing Address: _____
Email: _____ Phone: _____

Name: _____ Mailing Address: _____
Email: _____ Phone: _____

VIII. **VOLUNTEER PREFERENCES** Please indicate with a check those volunteer opportunities that interest you.

- Pro Bono Outreach Program – Host Site Program
- Pro Bono Outreach Program – Expansion/Private Practice Referral (must be licensed and in Private Practice/Have Office Space)
- Provide Supervision for a Candidate for Licensure
- Speakers' Bureau
- Health Fair
- General Media Contact
- Check Your Head (Teen Mental Health Awareness Program)
- Media Contact (9 HealthLine, Media Representative)
- Screening Day Volunteer
- Disaster Response DeBriefings

IX. MHAC PRIVATE PRACTICE REFERRAL INFORMATION. – **FOR THOSE INTERESTED IN ACCEPTING PB REFERRALS ONLY.**

Therapy/Office Address: _____
City/State/Zip: _____ Phone: _____

Is your office wheelchair accessible? _____
Is your office near an RTD Bus line/Light rail? _____ What line? _____

I agree to provide pro bono mental health care to (check all that apply):

- Children Couples
- Youth Adults
- Families Groups

I would like to work with clients who request assistance in the following areas:

- Anxiety disorders Depression PTSD
- Domestic Violence Mood Problems Sexual abuse
- Drug or Alcohol Abuse Grief Trauma care
- Drug dependency Faith-based Women's Issues
- Eating disorders Long term physical illness Other: please describe below
- Educational testing Medications _____

During the next 6 months I can commit to:

- One pro bono case OR more
- Two pro bono cases

What days and times are you generally available for a Pro Bono appointment?

M (am/pm) T (am/pm) W (am/pm) R (am/pm) F (am/pm) Weekends

Are you bilingual? _____ If yes, what language(s)? _____

XI. ETHICAL/LEGAL

Have you ever been disciplined for an ethical violation? Yes No

Have you ever settled a malpractice suit or had a malpractice judgment against you? Yes No

If you answered Yes to either or both of the above questions, please attach an explanation of the nature of the action(s) brought against you, the current status of the action(s) and pertinent dates. If applicable, explain the consequences resulting from the action(s). Thank you.

I hereby authorize Mental Health America of Colorado to verify any of the information above. I do not have a health condition, including alcohol or drug dependence that affects or is reasonably likely to affect my ability to perform my professional duties appropriately.

SIGNATURE: _____ DATE: _____

Please complete and return to:

Mental Health America of Colorado
1385 S. Colorado Blvd., Ste. 610, Denver, Colorado 80222
720.208.2220 / 800.456.3249 / 720.208.2250 *fax*
lmartin@mhacolorado.org * www.mhacolorado.org