Texas Podiatric Medical Foundation
San Miguel Mission
Volunteer Information Form

Name: ______________________ D.O.B.: ____________

Address ______________________ Do you speak Spanish? **Y / N**

____

Office Phone: (   ) ____________ Home Phone: (   ) ____________

Office Fax: (   ) ____________ Mobile Phone: (   ) ____________

Emergency Contact: ____________ Relationship: ____________

Phone: (   ) ____________ Mobile: (   ) ____________

Current Malpractice Carrier: ______________________

Limits of Liability: ______________________

*Malpractice not required, but encouraged.

I am able to volunteer for the general clinic: **Y / N**

I am able to volunteer for the surgical procedures & general clinic: **Y / N**

OPTIONAL INFORMATION

Current Medical Conditions: ______________________

Current Medications: ______________________

Please Attach:

1. **A list of your current procedures and/or privileges at your hospital(s)/surgical center(s); and**
2. **A copy of your malpractice face sheet, if current.**

The undersigned podiatric physician hereby agrees to indemnify, save and hold harmless the *Texas Podiatric Medical Foundation, Inc. (Foundation) and all participating residency programs* from and against any and all liabilities, claims, losses, damages, causes of action and expenses caused or arising from, directly or indirectly, any and all acts or omissions done or not done by the *Foundation* in connection with the *Niños de la Frontera Program.*

______________________ ____________

Signature **Date**

____

Printed Name

The Volunteer Information Form **MUST** be provided to the TPMF before you participate in the Foundation Mission Project. Please forward the form and requested documents to :

918 Congress Avenue, Suite 200
Austin, Texas 78701

(512) 494-1124, or (512) 494-1129 fax