JEAN B PURVIS COMMUNITY HEALTH CENTER OF BUTLER COUNTY

103 Bonnie Drive, Butler, PA 16002 | 724.841.0980 | www.butlerhealthclinic.org

FREE CLINIC FEDERAL TORT CLAIMS ACT (FTCA) PROGRAM

Patient Notice of Limited Liability for FTCA Deemed Free Clinic Volunteer Health Care Professionals, Board Members, Officers, Employees, and Independent Contractors

Notice to Patients To be provided to the individual patient before health care services are provided, except in emergency cases when notice may be provided as soon after the emergency as is practicable or to a parent or legal guardian when the patient lacks legal responsibility for his/her care under State law.

This is to notify you that under Federal law relating to the operation of free clinics, the Federal Tort Claims Act (FTCA), (See 28 U.S.C. §§ 1346(b), 2401(b), 2671-80) provides the exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions by any free clinic volunteer health care practitioner, board member, officer, employee, or independent contractor who the Department of Health and Human Services has deemed to be an employee of the Public Health Service. This FTCA medical malpractice coverage applies to deemed free clinic volunteer health care practitioners, board member, officer, employee, or independent contractor who have provided a required or authorized service under Title XIX of the Social Security Act (i.e., Medicaid Program) at a free clinic site or through offsite programs or events carried out by the free clinic (See 42 U.S.C. § 233(a), (o)).

The above Federal law and other State and Federal laws including the Federal Volunteer Protection Act of 1997 may cover certain free clinic health care professionals providing health care services to patients at this free clinic – Jean B Purvis Community Health Center (CHC).

By signing below, you acknowledge that you have received a copy of this Federal Tort Claims Act.

Print Name ________________________________ Signature________________________________ Date_____________

AUTHORIZATION FOR VERBAL COMMUNICATION & MEDICATION PICK-UP

I authorize CHC to verbally communicate my medical information with the following individuals. The individuals listed below are also given permission to pick up my medications from the CHC if I am unable to pick them up in person.

________________________________	________________________________
Name (Please Print)	Relationship to Patient
________________________________	________________________________
Name (Please Print)	Relationship to Patient

Print Name ________________________________ Signature________________________________ Date_____________