Physicians CareConnection
An affiliate of the Columbus Medical Association

1390 Dublin Rd. Columbus OH 43215
Tel: (614) 884-2441 Fax: (614) 884-0123
www.pcchealth.org

DENTAL VOLUNTEER APPLICATION

Our community dental collaborative provides dental care services to Central Ohio residents who are experiencing access barriers to affordable oral health.

Volunteer Dentists have a choice of how to volunteer: Either see patients at our physical clinic operated on Monday evenings at the Columbus Public Health Department or, see PCC patients in their own practice.

MONDAY NIGHT DENTAL INITIATIVE

- The Monday night clinic is located on the 2nd floor of the Columbus Public Health Department, on 240 Parsons Avenue. Clinic hours are from 6:00 pm - 9:00 pm
- Dentist must possess a current Ohio license to practice
- Physicians CareConnection provides a full liability insurance coverage for all volunteers
- You may pledge to volunteer to see patients at the clinic for Extractions on the 1st and 3rd Mondays. Please sign-up for scheduling on: http://signup.com/go/NmhRdgi

Providers volunteering at the Monday Night Clinic will receive the following support services when providing care to patients:

- Central staff to coordinate patient care
- Medical interpreters
- In- house pharmacy or linkage to Prescription Assistance Programs (PAPs)
- A scheduling and patient tracking system

Please fill out this form so that we can be efficient in our communication and feedback process.

VOLUNTEER INFORMATION!

YES! I would like to volunteer at the Monday Night Dental Initiative:

☐myself *OR* ☐my group (please check one)
I/we pledge to accept _____ (enter number) Monday nights/ year, to provide the following services:

☐Extractions ☐Other (please specify) **. . . . . .**

YES! I or my group would like to pledge to see patients in my practice to offer the following services: ☐Extractions ☐Other (please specify: **. . . . . .**

I/we pledge to accept _____ (Please enter the number of patients you or your group are willing to accept the first year).

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GROUP NAME: _____ (please print)

DOCTOR NAME(S): _____

Please provide us with your preferred mode of communication:

PHONE Number: (_____) _____ _____

FAX Number: (___) _____ _____

EMAIL _____@_____

PRACTICE INFORMATION:

Specialty: _____

Practice Name: _____

Address/city/state/zip _____

Office Manager/Administrator's name:_____

Office Manager/Administrator's phone number:_____

HOSPITAL AFFILIATION/PREFERENCES:

Please let us know your hospital affiliation/preference(s). This information will be used to manage the flow of referrals between doctors in the community. We will make every attempt to manage doctor referrals within your hospital preference(s). Please select your hospital preference(s) from the list below:

_____ Mt. Carmel Health Systems
_____ OhioHealth
_____ The Ohio State Wexner Medical Center
_____ No Hospital Preference

We will be contacting your office manager/administrator to schedule a training session. Our goal is to provide an organized, efficient system of care for our patients and the volunteer dentists. We will provide you with monthly updates of activities and progress. Please contact Bibiana Lagos, if you have questions at: (614-884-2441) or blagos@pcchealth.org. Please return your completed application via fax (614-884-0123) or mail to: Physicians CareConnection 1390 Dublin Rd., Columbus, OH 43215.