

3. Must document all injury/illness encounters, daily treatment logs and athlete visits.
4. Must ensure that all records are legible and complete.
5. Must follow all established procedures for the evaluation and treatment of athletes, coaches and guests in the cases of injury, illness, or other emergency, as outlined by the USOC medical staff.
6. Must assist in the medical care for athletes in the Sports Medicine Clinic, including pre and post training requirements, bracings, taping, manual therapy, stretching and physical modality treatments.
7. Must cover field events as assigned.
8. Must interface with local community medical resources.
9. Must understand doping control/drug testing regulations and procedures.
10. Must assist with daily duties in the clinic including cleaning and laundry duties.
11. Must assist with pre-practice set-up, post-practice tear-down, and attendance of all practices and competitions of the assigned sport.

V. SPORTS MEDICINE VOLUNTEER PROGRAM PROGRESSION:

Every volunteer must start at Level 1. Progression to the next level is not guaranteed. Progression is based on cumulative evaluations and event coverage needs.

Level 1 Two weeks (14 consecutive days) at one of the Olympic Training Centers (Colorado Springs, Colorado; Lake Placid, New York; or Chula Vista, California).

Level 2 A National or International competition appointment by USOC invitation or by invitation of an NGB with USOC support. Examples:

- NGB National Championships,
- NGB Regional & National Events,
- World University Games (Summer or Winter),
- National USOC-endorsed Games,
- International USOC-endorsed Games.

This may require 3 or more weeks of service. Transportation, room & board are typically provided.

Level 3 International Games Appointment by USOC invitation or by invitation of an NGB with USOC support. Examples:

- Pan American Games,
- Para-Pan American Games,
- International Federation World Championships,
- International Federation World Cup Events
- International USOC endorsed Games.

This may require 3 or more weeks of service with transportation and room & board provided by the USOC.

Level 4 International Games Appointment by USOC invitation

- Olympic Games
- Paralympic Games
- Youth Olympic Games

This usually requires 3 or more weeks of service with transportation and room & board provided by the USOC.

VI. VOLUNTEER EVALUATION:

To help ensure the selection of a qualified and compatible medical team; at each level, athletes, medical staff, administrative staff, and NGB staff evaluates the sports medicine volunteer based on:

- Medical skills,
- Rapport with
 - Athletes,
 - Coaches,
 - Administrative staff,
 - Medical staff,
 - Sport officials,
 - Sport administration officials,
 - Sports Performance Staff
 - Exercise physiologists,
 - Nutritionists,
 - Sports Psychologists,
 - Strength and Conditioning Specialists,
- Adherence to policies of the USOC

**UNITED STATES OLYMPIC COMMITTEE
SPORT PERFORMANCE DIVISION MEDICAL VOLUNTEER PROGRAM
Doctor of Chiropractic Application**

FULL LEGAL NAME: _____ Date of Application: _____

_____ Social Security # _____

Sex: _____ Date of Birth _____ U.S. Citizen? Yes _____ No _____
Month Day Year

Passport # _____

<u>Work Address:</u>	<u>Home Address:</u>
_____	_____
_____	_____
_____	_____
County: _____	County: _____
Telephone: _____	Telephone: _____
Cell: _____	Cell: _____
FAX: _____	FAX: _____
E-mail: _____	E-mail: _____

*****You are responsible for keeping your address and telephone number up-to-date with the USOC*****

EDUCATION

Institution Granting Degree: _____

Date? _____

Address: _____

City State Zip Country

Highest Degree: _____

Specialty Training: _____

Do You Have Specialty Training Beyond D.C.? If so, List: _____

PROFESSIONAL INFORMATION

Medical License – Please List All Professional Licenses Ever Held:

State	License #	Type	Effective Date	Currently Valid?
_____	_____	_____	_____	Yes _____ No _____
_____	_____	_____	_____	Yes _____ No _____

National Provider Identifier (NPI) Number: _____

Any Facilities Where You May Have Clinical Privileges:

Name	City, State	Type of Privileges (active, courtesy, provisional)	Are Privileges Restricted?
_____	_____	_____	Yes _____ No _____
_____	_____	_____	Yes _____ No _____

DO YOU SKI?

Yes _____

No _____

At what level?

Beginner _____

Intermediate _____

Expert _____

Professional Sports Medicine Society Memberships: _____

Are you Presently Working with any National Governing Bodies? If so, please list:

NGB Sport: _____ NBG Team: _____

Other Sport: _____ Other Team: _____

What Type of Care Do You Provide (i.e. Office, Practice, Competition)? _____

- Have you been unable to practice medicine during the last two years for any reason?

Yes _____ No _____

- Have you ever been convicted of a felony or any misdemeanor, or are you presently formally charged with committing a criminal offense? Yes _____ No _____

If the answer is yes, furnish details of the conviction, offense, location, date and sentence on a separate piece of paper.

- Do you have any physical or mental condition or substance abuse problem that could affect your ability to exercise your clinical privileges or that require an accommodation for you to exercise those privileges safely and competently?

Yes _____ No _____

- In the past three years, have you ever knowingly used any narcotics, amphetamines, or barbiturates, other than those prescribed for you by a physician? Yes _____ No _____

If your answer is yes, please furnish details on a separate piece of paper.

- During the past five (5) years, have you had any malpractice claims made against you? Yes _____ No _____

- Have you ever voluntarily relinquished your medical privileges? Yes _____ No _____

- Have you ever had any actions taken against your license to practice or professional certification, including restriction or suspension?

Yes _____ No _____

- I authorize the United States Olympic Committee Performance Services Division to make inquiries of law enforcement agencies and courts with respect to my public record. I make this authorization based upon the Code of Federal Regulations 1301.90,93.

"By accepting an invitation to serve as a volunteer Doctor of Chiropractic in the United States Olympic Committee Performance Services Medical Volunteer program, I understand that I will function without pay or recompense as a licensed Doctor of Chiropractic under the general supervision of its Medical Officer. I accept complete responsibility for the professional attentions that I provide or choose not to provide".

In signing this application, I affirm that all information is complete and accurate:

Signature: _____

Date: _____

If you are interested in volunteering, please complete this form in full and include application fee of \$100.00 to cover cost of credential verification, and return to:

***United States Olympic Committee
Sports Performance Division – Sports Medicine
1 Olympic Plaza
Colorado Springs, CO 80909***

NOTICE TO CALIFORNIA APPLICANTS - ONLY

You have a right to obtain a copy of any consumer report or investigative consumer report obtained by The United States Olympic Committee Performance Services Division by checking the box provided below. The report will be provided to you within three (3) business days after we receive the requested reports related to the matter investigated.

I request to receive a free copy of this report by checking this box.

Under section 1786.22 of the California Civil Code, you may view the file maintained on you USOC Performance Services Division during normal business hours. You may also obtain a copy of this file upon submitting proper identification and paying the costs of duplication services, by appearing at the USOC Performance Services Division in person or by mail. You may also receive a summary of the file by telephone. The agency is required to have personnel available to explain your file to you and the agency must explain to you any coded information appearing in your file. If you appear in person, a person of your choice may accompany you, provided that this person furnishes proper

United States Olympic Committee

MEDICAL CREDENTIALING RELEASE FORM

This authorization is provided in connection with my application for the United States Olympic Committee Sport Performance Medical Volunteer Program and/or participation in a USOC event.

All information provided in or in connection with my application is true and correct to the best of my knowledge and belief. I authorize the USOC Sport Performance Division to verify and supplement this information. I authorize anyone and all persons and organizations having knowledge of my professional qualifications and credentials to provide information to the USOC Performance Services Division including but, not limited to, PrimeSource Web; The National Practitioner Data Bank; The American Medical Association; The Federation of State Medical Boards; The American Board of Medical Specialties; USIS Commercial Services; any applicable state medical board(s); the Drug Enforcement Agency; any malpractice insurance carrier; any hospital, HMO or other medical facility where I have practiced; and, any state or federal government agency. This information to be provided hereunder includes, without limitation, favorable and unfavorable information, including any state or hospital disciplinary actions or proceedings, medical malpractice coverage and claims, suits and settlements, licensing and certification information, DEA registration, medical training, hospital affiliations, performance records, criminal records, and similar or related information.

I hereby release each person and organization described above from and against any and all liability caused by or related to any good faith communication pursuant to this authorization.

I understand that, if I am accepted by the USOC Sport Performance Division, re-verification of my credentials will be periodically required. Therefore, this authorization shall remain valid for so long as I maintain a professional relationship with the USOC Sport Performance Division. I may cancel this authorization at any time with written notice.

A photocopy of this authorization is as valid as the original.

_____ Practitioner Name (Print)	_____ Date of Birth	_____ Social Security Number
_____ Signature	_____ Date Signed	

Any Other Name(s) Possibly in Records and date when name was changed



United States Olympic Committee
Sport Performance Medical Volunteer
Curriculum Vitae form

NAME: _____ **DATE:** _____

PERSONAL

Date of Birth: _____

Place of Birth: _____

Employment History Including Current Employment and Addresses: SEVEN YEAR HISTORY

(Explain any lapses in employment or working history)

Current Employer: _____

Address _____

County and State _____

Telephone: _____

Dates of Employment **From:** _____ **to** _____

Brief Summary of Responsibilities _____

Previous Employer: _____

Address _____

County and State _____

Telephone: _____

Dates of Employment **From:** _____ **to** _____

Brief Summary of Responsibilities _____

Previous Employer: _____
Address _____
County and State _____
Telephone: _____
Dates of Employment From: _____ to _____
Brief Summary of Responsibilities

Previous Employer: _____
Address _____
County and State _____
Telephone: _____
Dates of Employment From: _____ to _____
Brief Summary of Responsibilities

Board Certification _____
Date _____

Professional Licensure State: _____ **License #:** _____ **Expires:** _____
State: _____ **License #:** _____ **Expires:** _____
State: _____ **License #:** _____ **Expires:** _____

Initial Physical Therapy license State: _____ **License #:** _____ **Date Acquired:** _____
Expired: _____

EDUCATION

Undergraduate	_____

Date Completed:	_____
Graduate	_____

Date Completed:	_____
Doctoral	_____

Date Completed:	_____
Medical	_____

Date Completed:	_____
Internship	_____

Date Completed:	_____
Residency	_____

Date Completed:	_____
Fellowship	_____

Date Completed:	_____

HONORS & AWARDS

LANGUAGES

