



UNITED STATES OLYMPIC COMMITTEE

Sport Medicine Division Volunteer Program

Doctor of Chiropractic Application Criteria and Procedures

Preface

Volunteer athletic trainers, chiropractic physicians, massage therapists, medical physicians, and physical therapists together with the United States Olympic Committee's (USOC) full-time medical staff provide collaborative, integrated, multidisciplinary health care services to athletes registered at the U.S. Olympic Training Centers (OTC) at Colorado Springs, Chula Vista and Lake Placid. Athlete load, (i.e. competitions, sport camps, and resident athletes) dictates the number of sports medicine rotations and the number of sports medicine volunteers invited per rotation at each Olympic Training Center. If selected to participate in the Sports Medicine Division Volunteer Program all travel to the USOTC is at the volunteer's own expense. The USOC will provide housing, meals, and transportation to and from the airport.

Purpose

The purposes of the USOC Sports Medicine Volunteer Program are to:

1. Identify highly qualified and skilled sports medicine healthcare professionals throughout the United States who are willing to participate in the USOC Sports Medicine Volunteer Program in support of Team USA.
2. Provide evidenced based sports performance medicine in support of the training and competition needs of elite and developing National Governing Bodies (NGB) athletes at the USOTC.
3. Identify qualified and skilled sports medicine healthcare providers who may work more closely with specific NGBs to assist them with their service and event needs.
4. Become familiar with policies, procedures, rules and guidelines of the USOC, International Olympic Committee (IOC), United States Anti Doping Administration (USADA) and the World Anti Doping Administration (WADA).

Application Process

1. Upon receipt of the completed application and required supporting documents, applications are entered into the USOC Sports Medicine Volunteer database. Once needs have been identified, invitations will be offered. Invitations are first-come, first served.
2. Required Application Documents:
 - Cover Letter
 - Program Application
 - Curriculum Vitae (USOC Form)
 - Resume or CV
 - Letter of reference from an individual who can attest to your role in sport and/or orthopedic practice (i.e. Supervisor, Team Physician, Athletic Director or Head Coach)
 - Copy of State License/Registration
 - Copy of Board of Certification Certificate
 - Copy of completed certifications and additional skillsets
 - Copy of Malpractice Insurance (medical malpractice declaration page)
 - Copy of current CPR/AED certificate
 - Non-refundable application fee of \$35.00



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Qualification Criteria

All Sports Medicine Volunteers:

1. Must be a citizen of the United States of America.
 - a. Non-U.S. citizens may be considered only if they are highly recommended by the administration of an NGB and have demonstrated a consistent history of care for the athletes in that NGB.
2. Must complete all requirements outlined in “Application Process” section above in full.
3. Must have three (3) years of ongoing professional experience post certification or licensure.
4. Must be actively engaged in the sporting community including providing care and sport orthopedic involvement within the past five (5) years (i.e. event volunteering, coverage, local sport team care)
5. May never have been convicted of a felony or any conviction for health care fraud.
6. May not have any disciplinary license actions.
7. May not have any actions, sanctions or discipline on clinical privileges or employment as the result of sexual abuse/harassment or substance abuse.
8. The USOC must be notified by the volunteer of any pending criminal charges or disciplinary action by any medical organization, board, or licensing agency as soon as they are filed at any time while serving in the USOC medical volunteer program.
9. Must be current on health care provider level CPR and AED.
10. Must have malpractice insurance,
 - a. The policy minimum is \$1,000,000 – 3,000,000.
 - b. Provide a current copy of the declarations page.
 - c. The malpractice policy must cover the applicant while volunteering for the USOC.
 - d. While volunteering, the volunteer’s insurance is primary; the USOC insurance policy provides excess coverage, if necessary.
 - e. If a health care practitioner is sued independent from the USOC for actions or inactions on behalf of the USOC, the USOC cannot guarantee that the volunteer will be covered by USOC insurance.
 - f. Applicants must disclose any malpractice claims.
11. Must submit a cover letter that summarizes their sports medicine experience with an emphasis on the last 2 years of sports medicine experience and why they would like to be a part of the USOC Sports Medicine Volunteer Program.
12. Must submit the \$35.00 application fee to help cover medical background check. Payment is by check made out to the USOC.

Chiropractic Sport Physician-Specific Requirements:

13. Must hold an active CCSP or DACBSP.
14. Must possess a current active state license and must provide a copy of this license.
15. May have no disciplinary actions pending on license.



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Volunteer Duties and Responsibilities

1. Work in conjunction with all medical professionals to provide continuity of care and a cohesive medical team.
2. Provide after-hour on-call emergency care and coverage as assigned.
3. Document all injury/illness encounters, daily treatment logs and athlete visits.
4. Ensure that all medical records are legible and complete.
5. 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. 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. Interface with local community medical resources.
8. Understand doping control/drug testing regulations and procedures.
9. Assist with daily duties in the clinic including cleaning and laundry duties.
10. Assist with pre-practice set-up, post-practice tear-down, and attendance of all practices and competitions of the assigned sport.

Sports Medicine Volunteer Program Benefits

Every volunteer who successfully completes a volunteer rotation is:

- 1.) Entered into the pool for the opportunity to participate in future rotations.
- 2.) Eligibility for consideration to cover U.S and international events hosted by the USOC and/or NGBs

Volunteer Evaluation

To help ensure the selection of a qualified and compatible medical team, USOC medical staff evaluates each Sports Medicine Volunteer on:

- Sports Medicine skills
- Professionalism
- Quality of work
- Rapport with:
 - Medical staff
 - Athletes
 - Coaches
 - Administrative Staff
 - Sport officials
- Sports Medicine Volunteer Adherence to policies of the USOC



UNITED STATES OLYMPIC COMMITTEE
Sport Medicine Division Volunteer Program
Doctor of Chiropractic Application

| | |
|--------------------------|----------------------------|
| Full Legal Name: _____ | Date of Application: _____ |
| Social Security #: _____ | Gender: Male Female |
| Date of Birth _____ | U.S. Citizen? Yes No |
| Month Day Year | Passport # _____ |

| <u>Work Address</u> | <u>Home Address</u> |
|---------------------|---------------------|
| | |
| | |
| Country: _____ | Country: _____ |
| 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*****

| |
|--|
| Contact Preference: Work / Home |
|--|

Education

| | |
|---|-------------|
| Institution Granting Degree: _____ | Date: _____ |
| Highest Degree: _____ | |
| Specialty Training: _____ | |
| Specialty Training Beyond D.C.? If yes, please list and provide supporting documentation: _____ | |
| _____ | |

Professional Information

| Medical License – Please List All Professional Licenses Ever Held: | | | | |
|--|-------------|---------------------------------|----------------------------|------------------|
| State | License # | Type | Effective Date | Currently Valid? |
| _____ | _____ | _____ | _____ | Yes No |
| _____ | _____ | _____ | _____ | Yes No |
| Facilities Where You Have Clinical Privileges: | | | | |
| Name | City, State | Privilege Type | Are Privileges Restricted? | |
| | | (active, courtesy, provisional) | | |
| _____ | _____ | _____ | Yes | No |
| _____ | _____ | _____ | Yes | No |
| National Provider Identifier (NPI) Number: _____ | | | | |



NGB Involvement

Are you presently working with any National Governing Bodies (NGBs)? Yes _____ No _____
If yes, please list: NGB Sport: _____ NGB Team: _____
NGB Sport: _____ NGB Team: _____

What type of care do you provide (clinical, practice, competition)?

Do you speak any foreign languages? Yes _____ No _____ If yes, please list : _____

Contact/Combat Sport Experience: _____

Non-Contact Sport Experience: _____

Skiing Ability

Do you ski? Yes _____ No _____

Skill Level: Beginner _____ Intermediate _____ Expert _____

Medical and Criminal History

Have you ever been convicted of a felony or any misdemeanor, or are you presently formally charged with committing a criminal offence? Yes _____ No _____
If the answer is yes, please provide details of the conviction, offence, location, dates, 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 completely?
Yes _____ No _____

In the past three years, have you ever knowingly used any narcotics, amphetamines, or barbiturates, other than those prescribed to you by a physician? Yes _____ No _____
If your answer 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 Sports Medicine 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 Sports Medicine Division 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. All information provided in my application is true and accurate and no sanctions have been placed on my license(s) or credential(s). I certify that I am in good standing for any specialty boards I have membership in:

Signature: _____

Date: _____

If you are interested in volunteering, please complete this form in full and include application fee of \$35.00 to cover cost of credential verification, and return to:

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



**UNITED STATES OLYMPIC COMMITTEE
Sport Medicine Division Volunteer Program
Curriculum Vitae Form**

| | |
|-----------------------------|------------------------------|
| Name: _____ | Date: _____ |
| Date of Birth: _____ | Place of Birth: _____ |

Employment History Including Employment Addresses: Seven (7) Year History
(Please explain any lapses in employment or working history)

| |
|---|
| Current Employer: _____ Address: _____ Country and State: _____ Phone: _____ Dates of Employment: From: _____ To: _____ Brief Summary of Responsibilities: _____ _____ |
| Previous Employer: _____ Address: _____ Country and State: _____ Phone: _____ Dates of Employment: From: _____ To: _____ Brief Summary of Responsibilities: _____ _____ |
| Previous Employer: _____ Address: _____ Country and State: _____ Phone: _____ Dates of Employment: From: _____ To: _____ Brief Summary of Responsibilities: _____ _____ |



Previous Employer: _____

Address: _____

Country and State: _____ **Phone:** _____

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

Brief Summary of Responsibilities: _____

Previous Employer: _____

Address: _____

Country and State: _____ **Phone:** _____

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

Brief Summary of Responsibilities: _____

Board Certification: _____ **Date:** _____

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

State: _____ **License #:** _____ **Expires:** _____

State: _____ **License #:** _____ **Expires:** _____

Other Certifications/License(s): _____

Current Professional Societies: _____



Education

Undergraduate Institution: _____

Degree Obtained: _____

Date Completed: _____

Graduate Institution: _____

Degree Obtained: _____

Date Completed: _____

Doctoral Institution: _____

Degree Obtained: _____

Date Completed: _____

Medical Institution: _____

Degree Obtained: _____

Date Completed: _____

Internship: _____

Date Completed: _____

Residency: _____

Date Completed: _____

Fellowship: _____

Date Completed: _____

Honors and Awards: _____
