



# UNITED STATES OLYMPIC COMMITTEE

## Sport Performance Division

### Sports Medicine Volunteer Program

### Selection Criteria and Procedures

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#### **Purpose**

The purposes of the United States Olympic Committee (USOC) Sports Medicine Volunteer Program are to:

1. Identify the most skilled/knowledgeable sports medicine healthcare professionals, throughout the United States, and refer elite athletes, coaches and National Governing Bodies (NGB) to them for health, medical issues and support related issues.
2. Provide performance based sports medicine support for the training and competition needs of elite and developing NGB athletes at the United States Olympic Training Centers (USOTC).
3. Identify the most skilled sports medicine healthcare providers and connect them with NGBs to assist them with their service and event needs.
4. Following the 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) educate, develop and provide a performance critical sports medicine team to support the needs of the US athletes at USOC supported events:
  - a. Pan American Games,
  - b. Para Pan American Games,
  - c. Youth Olympic Games,
  - d. Olympic Games, and
  - e. Paralympic Games.

#### **I. PREFACE:**

Volunteer medical physicians, chiropractic physicians, certified athletic trainers, physical therapists, and massage therapists, together with the USOC's full-time medical staff provide integrated, multidisciplinary health care services to athletes registered at the USOTC at Colorado Springs, Chula Vista and Lake Placid. The medical staff for USOC-sponsored competitions is selected from this pool of volunteers.

The number of volunteer applicants each year typically exceeds the spaces available at the USOC's sports medicine facilities. Therefore the following criteria are utilized to classify each applicant.

## **II. APPLICATION PROCESS:**

1. Upon receipt of the completed application and required supporting documents applications are dated and placed in order of arrival. Invitations are first-come, first served. Volunteers with NGB experience and recommendation will be granted priority.
2. Checklist of required documents:
  - Cover Letter
  - Program Application
  - Signed Credential Release Form
  - Curriculum Vitae (USOC Form)
  - Resume or CV
  - Letter of reference from NGB Administrator, Athletic Director, or Head Coach
  - Copy of professional license
  - Copy of Board Certification
  - Copy of Malpractice Insurance (medical malpractice declaration page)
  - Copy of current CPR/AED certificate
  - Copy of current First Aid certificate (Physical Therapists Only)
  - Photo Copy of Education Certificate (Massage Therapists Only)
  - Non-refundable application fee (a. \$30.00 for certified athletic trainers and massage therapists; b. \$100.00 for medical physicians, chiropractic physicians and physical therapists)
3. Athlete load, (competitions, sport camps and the number of resident athletes) dictates the number of sports medicine rotations and the number of sports medicine volunteers invited per rotation at each Olympic Training Center.
4. If selected to participate in the sport performance medical 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.
5. Applicants, who decline their first invitation, will have two additional opportunities for invitation within a two year period.
  - a. The applicant will be removed from active consideration after three unaccepted invitations within a two-year period.
  - b. The applicant must notify the USOC Sports Performance Medical Director if they wish to be re-considered for a future sports medicine rotation.

## **III. 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 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 the USOC curriculum vitae form, in full, and submit their CV or resume.
3. Sign the attached Credential Release form authorizing a background check.
4. Must have five years of ongoing professional experience post certification or licensure.

5. Must have provided on-site care for sports team(s) including attendance at practices and competitions during the previous two years.
6. Must submit a letter of recommendation from an NGB Administrator, Athletic Director, or Head Coach. The Letter of Recommendation must verify your position with the team, the type of medical services provided for the team(s) and the length of time worked with the team(s).
7. May never have been convicted of a felony or any conviction for Health Care fraud.
8. May not have any disciplinary license actions.
9. May not have any actions or sanctions or discipline on clinical privileges or employment as the result of sexual abuse/harassment, or substance abuse.
10. 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.
11. Must be current on health care provider level CPR and AED.
12. Must have malpractice insurance,
  - a. The policy minimum is \$1,000,000 – 3,000,000, and
  - 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 may not have excessive malpractice claims.
13. Must submit a cover letter that summarizes their sports medicine experience with an emphasis on the last 5 years of sports medicine experience and why they would like to be a part of the USOC Sports Medicine Volunteer Program.
14. Must submit the appropriate application fee to cover administrative costs and background checks. Payment is by check made out to the USOC.
  - a. \$30.00 for certified athletic trainers and massage therapists
  - b. \$100.00 for medical physicians, chiropractic physicians and physical therapists

### **Medical Physicians:**

1. Medical physicians must possess a valid state medical license in the state they are practicing and must provide a copy of the license.
2. Must currently be Board Certified.
  - a. A Certificate of Additional Qualification (CAQ) in sports medicine is strongly recommended.
  - b. Completion of the American College of Sports Medicine Team Physician Course series is recommended.
3. May not have any limitations, restrictions, or disciplinary sanctions against their medical licenses or DEA or CDS certificates.
4. Must have a current, valid DEA certificate.

### **Chiropractic Physicians:**

1. Chiropractic physicians must possess a valid state chiropractic license in the state they are practicing and must provide a copy of the license.
2. Must also possess at least one of the following credentials:
  - a. Certified Chiropractic Sports Physician (CCSP),

- b. Diplomate American Chiropractic Board of Sports Physicians (DACBSP),
  - c. Diplomate American Board of Chiropractic Orthopedists (DABCO),
    1. Must also have current certification in First Aid
  - d. Diplomate American Chiropractic Rehabilitation Board (DACRB)
    1. Must also have current certification in First Aid, or
  - e. Certified Athletic Trainer (ATC)
3. It is recommended that chiropractic physicians complete the American College of Sports Medicine Team Physician Course series.

### **Certified Athletic Trainers:**

1. Must be certified by the National Athletic Trainers' Association (NATA).
2. If residing in a state where athletic trainers are licensed, you must possess a valid state license and must provide a copy of the license.
3. May not have any disciplinary license actions.

### **Licensed Physical Therapists:**

1. Must possess a valid license in the state they are practicing and must provide a copy of the license.
2. A Sports Certified Specialist credential is strongly recommended.
3. May not have any disciplinary license actions.
4. Must have a current First Aid card.
5. Must have a current Healthcare Provider CPR/AED card.
6. Must have a current California licensure to provide services at the Chula Vista Olympic Training Center.
7. For service in Colorado Springs, must obtain verification from the home state licensing board that your license is in good standing. The USOC Sports Medicine department will submit this verification to the State of Colorado DORA.

### **Massage Therapists:**

1. Massage therapists must have a minimum of 750 hours of education. Documentation of education hours and graduation year are required.
2. Must have at least 5 years of experience providing care at athletic events.
3. Must have a current Healthcare Provider CPR/AED card.
4. Must provide a letter of reference from an event director, Chief Medical Officer, NGB administrator, athletic director, or head coach stating the time period they are/were actually involved in providing care for sports team(s)/events.
5. All massage therapists must also provide a copy of their massage therapy insurance including the association and amount of coverage.

## **IV. DUTIES AND RESPONSIBILITIES:**

### ***ALL SPORTS MEDICINE VOLUNTEERS:***

1. Must work in union with all medical professionals to provide continuity of care and a cohesive medical team.
2. Must provide after-hour on-call emergency care and coverage as assigned.

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,
- Youth Olympic 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

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**

**Certified Athletic Trainer**

**Licensed Physical Therapist**

Full Legal Name: _____	Date of Application: _____
Social Security #: _____	Sex: _____
Date of Birth _____ Month      Day      Year	U.S. Citizen? Yes _____ No _____
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
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**Education:**

Highest Degree: _____
Institute Granting Degree: _____
Specialty Training: _____

**Professional Information:**

Certified Athletic Trainers: _____
Are you NATA-BOC Certified? Yes _____ No _____ NATA-BOC Certification # _____ Date of Certification _____
State Athletic Trainer License Number (if applicable) _____
National Provider Identifier Number (NPI) Number: _____

<b><u>Licensed Physical Therapists:</u></b>					
<b>Current Physical Therapy License #:</b> _____		<b>State:</b> _____			
<b>CPR/AED Expiration Date:</b> _____					
<b>First Aid Certification Expiration Date:</b> _____ <i>(Required for PT's)</i>					
<b>State Licenses:</b>					
<b><u>State</u></b>	<b><u>License #</u></b>	<b><u>Type</u></b>	<b><u>Effective Date</u></b>	<b><u>Currently Valid?</u></b>	
_____	_____	_____	_____	Yes _____	No _____
_____	_____	_____	_____	Yes _____	No _____
_____	_____	_____	_____	Yes _____	No _____
_____	_____	_____	_____	Yes _____	No _____

<p><b>Do you have five years of ongoing professional experience post certification/licensure?</b> Yes _____ No _____</p> <p><b>This experience needs to be documented on our curriculum vitae form.</b></p>
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**ARE YOU PRESENTLY WORKING WITH A NATIONAL GOVERNING BODY SPORTS TEAM? IF SO, PLEASE LIST BELOW:**

**NGB SPORT:** \_\_\_\_\_ **NGB TEAM:** \_\_\_\_\_

**OTHER SPORT:** \_\_\_\_\_ **OTHER TEAM:** \_\_\_\_\_

**DO YOU SKI?** Yes \_\_\_\_\_ No \_\_\_\_\_

What level? Beginner \_\_\_\_\_ Intermediate \_\_\_\_\_ Expert \_\_\_\_\_

Have you ever had any actions taken against your license to practice or professional certification, including restriction, suspension, loss of clinical privileges for more than 30 days, or any criminal convictions? Yes \_\_\_\_\_ No \_\_\_\_\_

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 barbiturages, 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? If yes, please attach details. 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.

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.

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

***Signature of Applicant:*** \_\_\_\_\_ ***Date:*** \_\_\_\_\_

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***If you are interested in volunteering, please mail this application plus the application fee (\$30.00 for ATC's and \$100.00 for PT's) to cover background checks to:***

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

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**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 by 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 identification.

# 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 any and all persons and organizations having knowledge of my professional qualifications and credentials to provide information to the USOC Sport Performance 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**

_____
_____

