LOCUMCONNECTIONS

Instructions:

- Attach a current CV to completed application with all work and education history included.
- Please attach further information on any malpractice claims.
- Please be sure to sign the last page of the document.

Identifying Information

Last Name	First Name	Middle Name	Previous Surname	Suffix

Degree: MD ○ DO ○ MBBS ○ Other (Please Specify) ○ | Social Security Number

	NPI Number	Date of Birth*
Birth City	Birth State / Province	Birth Country*

Primary Practice Specialty	Secondary Practice Specialty

Are you able to work legally in the United States? ○ Yes ○ No
If yes, please indicate the following: ○ US Citizen ○ Visa or work authorization (*You may be asked to provide proof of eligibility to work in the US)*

Other than English, list all languages you speak:

* Used for credentials verification purpose only. LocumConnections does not discriminate on the basis of age, nationality, or other factors.

Preferred Address

Address	Apt. / Unit Number	Email	
City	State/Province	Zip Code	Country
Home Phone Number	Work Phone Number	Cell Phone Number	

Professional Liability

Have you **ever** been involved, directly or indirectly, in a malpractice claim(s), potential claim or suit arising out of the rendering or failing to render professional services (even if the suit was subsequently dropped or dismissed action)?
○ Yes (**If Yes, how many? ____ Please attach an explanation for each**.) ○ No

Has any monetary payment ever been made by you or on your behalf because of alleged medical malpractice? ○ Yes ○ No	Are there currently any pending or potential medical malpractice claims or settlements involving yourself rising from the rendering or failure to render services? ○ Yes ○ No

Has your professional liability insurance coverage ever been denied, limited, or canceled by the action of any insurance company? ○ Yes ○ No
If Yes, attach explanation on separate sheet

Has your professional malpractice liability insurance excluded any specific procedures from your insurance coverage or denied liability insurance coverage?
If yes, attach explanation on a separate sheet. ○ Yes ○ No

Residency Training

Have you completed at least three years of residency training in the United States or Canada?	○ Yes ○ No
Have you ever been placed on probation, asked to resign or actually resigned from an internship, residency, or any other training program?	○ Yes ○ No

Primary Board Certification

Are you Board Certified in your primary specialty?	○ Yes ○ No
Have any of your Board Certifications ever been suspended, revoked, withdrawn, terminated or voluntarily surrendered?	○ Yes ○ No

Medical License, Certifications and Privileges

Have any of your professional medical licenses, in any state, ever been limited, sanctioned, voluntarily / involuntarily surrendered, withdrawn, terminated, conditioned, denied or limited?	○ Yes ○ No
Have your privileges / affiliation at any hospital, facility, or managed care organization ever been voluntarily or involuntarily surrendered, denied, suspended, revoked, restricted, limited, terminated, withdrawn or placed on probation (even if they were subsequently reinstated?)	○ Yes ○ No
Has your DEA certificate or any state CDS certification ever been voluntarily or involuntarily suspended, restricted, revoked, surrendered, withdrawn, terminated, conditioned, denied or limited?	○ Yes ○ No

Adverse Actions

Have you ever been the subject of an investigation, suspended from, or sanctioned by any private, federal or state agency regarding your participation in a third party health payment program including but not limited to Medicare, Medicaid, HMO, PPO, PHO, PSHCC, MCO, network, or system?	○ Yes ○ No
Have you been the subject of an investigation or adverse action by a state or federal agency (e.g. DEA) regarding your prescription of controlled substances?	○ Yes ○ No
Have you ever been sanctioned, denied membership or renewal, or been subject to disciplinary action for a violation of ethical standards, rules or guidelines by a professional or medical organization, licensing board, medical society or healthcare organization?	○ Yes ○ No
Have you ever been the subject of any report(s) to a state or federal data bank, state licensing or disciplining entity including the National Practitioner Date Bank (NPDB) or Healthcare Integrity and Protection Data Bank (HIPDB)?	○ Yes ○ No
Have you ever been charged with or convicted of a felony or a misdemeanor, pleaded “nolo contendre” or have you ever been placed on probation for any offense other than a traffic violation (including any charges that were dropped or reduced)?	○ Yes ○ No
Have you ever been sanctioned, reprimanded, censured or otherwise disciplined in any manner by any federal, state or local licensing authority or other professional board or peer committee for conduct related to the use or abuse of alcohol or drugs?	○ Yes ○ No
Have you ever been addicted to a controlled substance that has affected your ability to perform the duties of a physician?	○ Yes ○ No

Premedical Education

College or University	Degree	Honors
Address	City	State/Province	Country
Zip Code			

Medical Education

Medical School				Phone
Address	City	State/Province	Zip Code	Country
Degree Awarded	Attended from (mm/yyyy)	Attended to (mm/yyyy)	Date of completion (mm/yyyy)	
US/Canadian Medical School: If Medical School is greater or less than 4 years, please explain.				

Fifth Pathway Education ◯Yes◯No (If yes, please complete this section.)

Institution				Phone
Address	City	State/Province	Zip Code	Country
Specialty	Program completed◯Yes No◯ (If No, please explain)	Attended from (mm/yyyy)	Attended to (mm/yyyy)	Date of completion (mm/yyyy)

Other Graduate School ◯Yes◯No (If yes, please complete this section.)

College or University				Phone
Address	City	State/Province	Zip Code	Country
Major	Degree Awarded	Attended from (mm/yyyy)	Attended to (mm/yyyy)	Date of completion (mm/yyyy)

Internship

Institution				Phone
Address	City	State/Province	Zip Code	Country
Type/Specialty	Program completed◯Yes No◯ (If No, please explain)	Program Chair	Attended from (mm/yyyy)	Attended to (mm/yyyy)

Residency(ies) ◯Yes◯No (If yes, please complete this section.)

Institution				Phone
Address	City	State/Province	Zip Code	Country
Type/Specialty	Program completed◯Yes No◯ (If No, please explain)	Program Chair	Attended from (mm/yyyy)	Attended to (mm/yyyy)
Institution				Phone
Address	City	State/Province	Zip Code	Country
Type/Specialty	Program completed◯Yes No◯ (If No, please explain)	Program Chair	Attended from (mm/yyyy)	Attended to (mm/yyyy)

Fellowship or Preceptorship ◯Yes◯No (If yes, please complete this section.)

Institution				Phone
Address	City	State/Province	Zip Code	Country
Type/Specialty	Program completed◯Yes No◯ (If No, please explain)	Program Chair	Attended from (mm/yyyy)	Attended to (mm/yyyy)

Board Certifications

Name of Specialty Board	**Certified?**	**Date (mm/yyyy)**	**Recertified?**	**Date (mm/yyyy)**
	◯Yes◯No		◯Yes◯No	
	◯Yes◯No		◯Yes◯No	

If not board certified, have you been accepted to take a specialty examination? **◯Yes◯No**
Date Scheduled: _____

If not board certified, how many times have you taken a specialty board examination and failed to pass? _____

Work History ◯Yes◯No (If yes, please complete this section)
List all employment in month/year format since completion of post-graduate education. Please list hospital affiliations where you have held privileges. If there are any gaps in your work history, please explain on a separate sheet of paper.

Name of Practice/Institution		Was this a locum tenens position? ◯Yes◯No		Phone
Address	City	State/Province	Zip Code	Country
From (mm/yyyy)	To (mm/yyyy)	Position held:		
Name of Practice/Institution		Was this a locum tenens position? ◯Yes◯No		Phone
Address	City	State/Province	Zip Code	Country
From (mm/yyyy)	To (mm/yyyy)	Position held:		
Name of Practice/Institution		Was this a locum tenens position? ◯Yes◯No		Phone
Address	City	State/Province	Zip Code	Country

From (mm/yyyy)	To (mm/yyyy)	Position held:

Professional Licenses & Controlled Substance Permits *Please list ALL **current** state medical licenses and state controlled substance permits.*

State	License Number	Date Issued (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)	Controlled Substance Permit Number	Date Issued (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)

Inactive Licenses ○ **Yes** ○ **No (If yes, please complete this section)**

List all states with inactive licenses

DEA Registration ○ **Yes** ○ **No (If yes, please complete this section)**

Registration Number	Date issued (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)
Registration Number	Date issued (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)
Registration Number	Date issued (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)

If you do not currently possess a DEA Registration, please explain here:

ECFMG / FMGEMS ○ **Yes** ○ **No (If yes, please complete this section)**

Certificate Number	Date Issued

Military Service ○ **Yes** ○ **No (If yes, please complete this section)**

Branch	Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)

Status: ○ Active ○ Honorable Discharge ○ Dishonorable Discharge ○ Other (please specify)

Professional Liability Insurance *List all carriers for the past five years. Attach additional pages if necessary*

Present Carrier				Policy Number	
Coverage Limits				Expiration Date	Years with Company
Address	City	State/Province	Zip Code		Country
Previous Carrier				Policy Number	
Coverage Limits				Expiration Date	Years with Company
Address	City	State/Province	Zip Code		Country

Hospital Affiliations ○ **Yes** ○ **No (If yes, please complete this section)**

List all current hospital appointments and any held within the past five years. Please attach an additional page if more space is necessary.

Hospital		Formerly Known as		Phone
Address	City	State/Province	Zip Code	Country
Department/Service		Division Chief		Staff Category
Start Date (mm/yyyy)	End Date (mm/yyyy)		Percent of annual admissions/caseload	
Hospital		Formerly Known as		Phone
Address	City	State/Province	Zip Code	Country
Department/Service		Division Chief		Staff Category
Start Date (mm/yyyy)	End Date (mm/yyyy)		Percent of annual admissions/caseload	
Hospital		Formerly Known as		Phone
Address	City	State/Province	Zip Code	Country
Department/Service		Division Chief		Staff Category
Start Date (mm/yyyy)	End Date (mm/yyyy)		Percent of annual admissions/caseload	

Licensing Examinations *Please attach copies of your exam scores, if available.*

Circle original licensing exam:			
○ *COMLEX*	Step 1: First exam attempt date	No. of times taken	Date of completion (mm/yyyy)
○ *COMVEX*			
○ *FLEX*	Step 2: First Exam attempt date	No. of times taken	Date of completion (mm/yyyy)
○ *National Board*			
○ *NBOME*	Step 3: First exam attempt date	No. of times taken	Date of completion (mm/yyyy)
○ *SPEX*			
○ *State – If State, which state?*			
○ *USMLE*			
List any other licensing exams you have taken: Name:		No. of times taken	Date of completion (mm/yyyy)
Name		No. of times taken	Date of completion (mm/yyyy)

Physician Last Name	Physician First Name	Previous Surname	Suffix

Release and Authorization

I hereby affirm that the information I have provided on this application and attachments is true and correct and that it can be relied upon by LocumConnections and its affiliates for evaluating my potential as a locum tenens physician.

By applying for membership to, or when evaluating retention with LocumConnections, I hereby authorize LocumConnections, its affiliates and successors, to obtain any information that may be relevant to an evaluation of my professional qualifications, including but not limited to information about disciplinary actions or other confidential or privileged information, and other credentials.

I agree to provide and authorize the release by LocumConnections to LocumConnections' clients of the following: a) vaccination records; b) reasonable documentation evidencing that I am in good health and free of communicable diseases; c) the result of and/or a copy of my criminal background check, if any; and d) the result of and/or a copy of my drug screen, if any.

I authorize LocumConnections to disclose and to receive from current , prior, or potential employers and LocumConnections clients making a reasonable inquiry, information relating to my qualifications, ability, and character to practice medicine, including information from the following sources: all medical schools, colleges, universities, transcript offices, medical institutions, or organizations, hospitals, employers, personal references, physicians, attorneys, companies or agencies who may furnish my criminal background history, companies that perform drug screens, medical malpractice carriers or organizations, business and professional associates, all government agencies and instrumentalities, the National Practitioner Databank, the Federation of State Medical Boards, the American Medical Association, American Osteopathic Association, American Board of Medical Specialties, DEA, state licensing boards, and any other pertinent source. This is a continuing authorization until such time as I have specifically revoked the same in writing which shall apply to all information received at any time by LocumConnections relating to my qualifications, ability, and character to practice medicine.

I hereby forever waive and release LocumConnections, its officers, employees, agents and third parties which provide or receive information regarding my credentials, including but not limited to the Federation of State Medical Boards, and those entities listed above, from any claims, causes of action, damages and expenses, including reasonable attorney's fees arising from or relating to the provision, collection, verification, and dissemination of information about me.

Further, I agree to hold LocumConnections harmless from any and all claims, causes of action, damages, judgments and expenses, including reasonable attorney's fees, arising from or related to the collection, verification and dissemination of credentialing information provided by me. I understand that this does not contemplate a duty to hold LocumConnections harmless from claims, causes of action and damages which may arise as a result of information provided about me from sources other than myself.

I understand that I have the burden of providing accurate and adequate information to LocumConnections, its affiliates or successors, to demonstrate my qualifications. I understand that any misstatement in this form may constitute grounds for denial of referral to practice opportunities, grounds for civil damages, grounds for reporting the same to the NPDB or state licensing boards or cancellation of contract. If any material changes occur affecting my professional status, it is my obligation to notify LocumConnections or the appropriate affiliate or successor as soon as possible. I attest that information contained in this application is correct and complete.

I understand that the decision to refer me to practice opportunities by LocumConnections is solely at the discretion of LocumConnections.

I understand that any information received by references from LocumConnections, including but not limited to quality evaluations, is confidential and may not be released to me without the consent of the reference.

A copy or facsimile of this document shall have the same effect as the original.

This document shall be interpreted according to the laws of the State of Georgia.

Name:	Social Security Number:
Signature:	Date:

Professional References *Please list at least four professional references within your specialty with whom you have had* ***CLINICAL*** *contact in the past two years. They must be able to assess your professional skills and capabilities. Verbal references will be kept confidential. When possible, please let the reference know that LocumConnections will be calling. If you are just completing a residency or fellowship, please list your program chair as one of the references.* *<u>If you are unable to provide two same-specialty references, an explanation is required.</u>*

Name		Position/Relationship		Work Phone	Fax
Address		Primary Practice Specialty		E-Mail	Home or Cell Phone
City	State/Province	Zip	Country	Worked with from (mm/yyyy)	Worked with to (mm/yyyy)
Name		Position/Relationship		Work Phone	Fax
Address		Primary Practice Specialty		E-Mail	Home or Cell Phone
City	State/Province	Zip	Country	Worked with from (mm/yyyy)	Worked with to (mm/yyyy)
Name		Position/Relationship		Work Phone	Fax
Address		Primary Practice Specialty		E-Mail	Home or Cell Phone
City	State/Province	Zip	Country	Worked with from (mm/yyyy)	Worked with to (mm/yyyy)
Name		Position/Relationship		Work Phone	Fax
Address		Primary Practice Specialty		E-Mail	Home or Cell Phone
City	State/Province	Zip	Country	Worked with from (mm/yyyy)	Worked with to (mm/yyyy)

DISCLOSURE AND AUTHORIZATION FORM
TO OBTAIN CONSUMER REPORTS FOR EMPLOYMENT PURPOSES

DISCLOSURE

In considering you for employment (or engagement as an independent contractor[1]), LocumConnections, and/or its affiliates ("the Company") may request and rely upon one or more "consumer reports" about you that we obtain from IntelliCorp Records, Inc., a consumer reporting agency.

For explanation purposes a "consumer report" includes any written, oral or other communication by a consumer reporting agency that bears on your character, general reputation, personal characteristics, or mode of living which is used for the purpose of making an employment-related decision about you. Such information may include, the following:

- o Social Security Number Verification
- o Criminal Records Search
- o Nationwide Sexual Offender Database Search
- o Terrorist Watchlist
- o OIG Exclusions Database
- o Single County Criminal Search

Under the Fair Credit Reporting Act ("FCRA"), before the Company can obtain a "consumer report" about you for employment purposes, we must have your written authorization. Before we take adverse action on the basis, in whole or in part, of information in that report, you will be provided a copy of that report, the name, address, and telephone number of the consumer reporting agency, and a summary of your rights under the FCRA.

AUTHORIZATION

I have read and understand the foregoing Disclosure, and authorize the Company to obtain and rely upon consumer reports in considering me for employment and, if I am employed, in considering me for subsequent promotion, assignment, reassignment, retention, or discipline. By my signature below, I authorize the Company to obtain any such reports and to share the information received with any person involved in the employment decision about me.

I do ___O___ do not ___O___ authorize you to contact *my current* employer for Employment and Reference Verifications

(This will authorize immediate inquiries to the Human Resources Department and to any listed supervisors or references in the Employment/Reference Section of your application.)

I also agree that this Disclosure and Authorization in original, faxed, photocopied, or electronic (including electronically signed) form will be valid for any consumer reports that may be requested about me by or on behalf of the Company.

_____ _____

Applicant Signature Date

[1] For purposes of this Disclosure and Authorization, the term "employment" also includes engagement as an independent contractor. Under the FCRA, the terms "employment" or "employ" are interpreted liberally and may apply to situations where an entity uses individuals who are not technically employees to perform duties.

Personal Data

Last Name | First Name | Middle Name

Current Address (include street, city, state, zip code) | Dates Lived Here

Addresses for the Past Seven Years: (include street, city, state, zip code) | Dates of Residence:

Date of Birth | Other Names Used (including maiden name) | Years Used

Social Security Number | Driver's License # | State

Email address (may be used for official correspondence)

I have the right to make a request to **IntelliCorp Records, Inc**, upon proper identification, to request the nature and substance of all information in its files on me at the time of my request, including sources of information, and the recipients of any reports on me which **IntelliCorp Records, Inc** has previously furnished within the two year period preceding my request.

I certify that all of elements of the personal data I have provided are true, accurate and complete. I understand and agree that any omission, false statement, misleading statement, or answer made by me on my application or any supplements to it and in any interviews will be sufficient grounds for rejection of employment and my discharge after employment.

Printed Name | Applicant Signature | Date

INFORMATION ON STATE LAW REQUIREMENTS

1. WITH REGARD TO INDIVIDUALS WHO ARE OR WILL BE EMPLOYED IN CALIFORNIA, MINNESOTA, AND OKLAHOMA:

☐ **You may request a free copy of any consumer report we obtain on you by checking the box.**

2. WITH REGARD TO INDIVIDUALS WHO ARE OR WILL BE EMPLOYED IN CALIFORNIA:

Pursuant to California Civil Code §§ 1786.16(a)(2) and 1786.22, you are advised as follows:

We will be obtaining a consumer report from Intellicorp Reports, Inc., 3000 Auburn Dr., Ste 410, Beachwood, OH 44122 telephone: (216) 450-5200. You have the right to request from that agency, upon proper identification, the nature and substance of all information in its files on you, including the sources of information, and the recipients of any reports on you, which the agency has previously furnished within the three-year period preceding your request. You may view the file maintained on you by the agency during normal business hours. You may also obtain a copy of this file upon submitting proper identification and paying the costs of duplication services. Upon making a written request, you may receive a summary of your report via telephone.

3. WITH REGARD TO INDIVIDUALS WHO ARE OR WILL BE EMPLOYED IN NEW YORK:

Under Article 25 Section 380-g of the New York General Business Law, if an employer receives a consumer report containing criminal conviction information, the employer must provide the applicant or employee who is the subject of the report, a printed or electronic copy of Article 23-A of the New York Correction Law, which governs the employment of persons previously convicted of one or more criminal offenses.

LOCUMCONNECTIONS

ACKNOWLEDGEMENT OF
INDEPENDENT CONTRACTOR STATUS

I acknowledge and agree that my engagement by LocumConnections ("Connections") is and will be as an independent contractor, and not as an employee, partner, or agent, of Connections or its affiliates or clients.

In this regard, I expressly acknowledge, understand, and agree as follows:

1. I will determine independently the coverage assignments I will accept; I will not be required by Connections to accept any particular assignment or any assignment whatsoever.

2. I will be solely responsible for my professional actions in providing medical services to patients at clients' facilities or elsewhere.

3. My first duty at all times shall be to my patients, and I will exercise independent professional judgment regarding the care and treatment of my patients.

4. Connections will not direct or control my professional medical services in any manner, including the time, place, type, or quality of professional services, working conditions, the right to utilize or hire assistants, or the prices charged for medical services rendered by me.

5. I will not have any authority to charge any item or incur any debt or other financial obligation on behalf of Connections or undertake any obligation or enter into any agreement on behalf of Connections.

6. I will not represent at any time that I am an employee of Connections or any client or that I am authorized to make any contract, covenant, or obligation on behalf of Connections or any client.

7. Payments made by Connections to me pursuant to this Agreement, if any, will be made by Connections on behalf of its clients.

8. Connections will not deduct, withhold and pay FICA, federal income tax, state income tax, workers' compensation insurance premiums, state disability insurance, unemployment benefit insurance, or any other payments that are ordinarily withheld or submitted by an employer for or on behalf of an employee; I understand that I will not be entitled to any unemployment benefit insurance, or any other payments that are ordinarily withheld or submitted by an employer for or on behalf or an employee; I understand that I will not be entitled to any unemployment, disability, or workers' compensation benefits from Connections.

9. I will be solely responsible for, and I will pay in a timely manner, all federal, state, and local income or self-employment taxes due on monies paid by Connections to me. I agree to indemnify and hold Connections, its affiliates, and its clients harmless for any liability claims (including attorney's fees and expenses) incurred in connection with my failure to comply with this obligation.

PROVIDER

_____
Signature

Name: _____

Date: _____

LOCUMCONNECTIONS

Clinical Skills Checklist

Please list any limitations, comments, or concerns on a separate sheet of paper.

Identifying Information	Last Name	First Name	Middle Name	Previous Surname		
				Date of Birth		
Certifications	☐BLS	☐ACLS	☐ATLS	☐NALS	☐PALS/APLS	☐NRP
	Expires:	Expires:	Expires:	Expires:	Expires:	Expires:

Areas of Interest

☐Inpatient Medicine ☐Outpatient Medicine ☐Other: (Please list below)

☐Hospitalist ☐Occupational medicine

☐ICU/CCU ☐Acute Ambulatory care (urgent)

Scope of Practice

Please check the box indicating which clinical capabilities you are able to perform, and where indicated (‘#), list the approximate number performed within the last 24 months. Residents, please list for the past 36 months.

Clinical Area/Procedure	Clinical Area/Procedure			
Medicine:	Occupational Medicine:			
☐ Adult Outpatient	☐Employment Physicals			
☐ Adult inpatient	☐ Disability Exams			
☐ w/out ICU/CCU ☐ w/ ICU/CCU	☐ Diagnosis and management of common industrial-related medical problems			
Pediatric:	OB:			
☐ Newborn care (>2000gms)	☐ Prenatal care			
☐ General inpatient	Date of last delivery:			
☐ General Outpatient				
☐ Newborn Resuscitation	*Physician who recently completed residency must provide the last 36 months.	Within last 12 months	Within last 12-24 months	Within last 24-36 months*
Gyn:	Vaginal Deliveries	#	#	#
☐ Pelvic Exam/Pap Smear	C-Sections	#	#	#
☐ Colposcopy	VBAC	#	#	#
☐ Endometrial Biopsy ☐ IUD insertion and removal	Instrument assisted deliveries (forceps, vacuum, etc.)	#	#	#
☐ DNC	Ultrasounds:	#	#	#

Orthopedic:	Procedures:	Within last 12 months	Within last 12-24 months	Within last 24-36 months*
☐ Non-displaced fractures	☐ Ventilation management	#	#	#
☐ Trigger Point / Joint Injections	Insertion of:			
	☐Central Line	#	#	#
Surgery:	☐ Arterial Line	#	#	#
☐ Surgical assisting	☐ PA Catheter	#	#	#
☐ Skin/tissue biopsy	☐ EKG Interpretation (Unofficial)	#	#	#
☐ Suturing of minor lacerations	Diagnostic/therapeutic taps:			
☐ I & D (Incision and Drainage)	☐ Lumbar Puncture	#	#	#
	☐ Paracentesis #	#	#	#
Psychiatric::	☐ Thoracentesis #	#	#	#
☐ Uncomplicated adult				
☐ Uncomplicated child/adolescent	☐ Evaluation and management of acute volume / BP issues			
☐ Uncomplicated geriatric				

Sign:	Date:

LOCUMCONNECTIONS

5901-C Peachtree Dunwoody Road, Suite 350
Atlanta, GA 30328
(877) 563-0535

LocumConnections Physician Reimbursement Policy

EXPENSE POLICY

- In order to ensure that your pay and reimbursements are processed without delay, expenses must be submitted with your timesheet
- Those that are received after the deadline will be processed the following pay period
- Request for reimbursement must be submitted within 15 days of the assignment ending OR at minimum once a month for long term assignments
- Keep your receipts for any expenses you incur as receipts are required and must be submitted with your timesheet to be reimbursed
- All expenses MUST be approved by Client and/or LocumConnections in advance – unapproved expenses will not be paid
- Provider is liable for any additional expenses incurred outside of agreement or due to changes in flight times or other travel Arrangements

REIMBURSABLE EXPENSES

- **Transportation**:
  Baggage Fees, Coach Airfare, Gas for Rental Car or Mileage for use of Personal Car (at IRS tax rate), Rental Car, Taxi, Tolls
- **Car Rental**:
  Rentals vehicles will be arranged by LocumConnections and all payment is set up direct bill (Car Rentals do not include LocumConnections insurance). If provider has to pay cost out of pocket, charges shall be covered under this section.
  Please remember to always refuel rental car prior to returning.
- **Parking**:
  Airport / Hotel

NON REIMBURSABLE EXPENSES

- **Airline**: Change Fees, Upgrades, Lost Ticket, Spouse or Family Travel
- **Hotel**: Meals, Phone, Video / Movies, Upgrades, No Show Fees
- **License**: Medical License and DEA (Must be pre-approved and have documented evidence for reimbursement)
- **Personal**: Cleaning, Cell Phone, Fax, Pets, Damages, Cable, Spouse or Family Travel
- **Rental Car**: Car Upgrades, Mileage, GPS, Refueling Charges, Satellite Radio

EXCEPTIONS

If the Client and/or LocumConnections have agreed to any exceptions beyond this policy, your LocumConnections representative will facilitate and document the arranged approval. **EXPENSES NOT PRE-APPROVED BY LOCUMCONNECTIONS MAY BE REFUSED**.

PROVIDER

_____
Signature

_____
Name: Date:

LOCUMCONNECTIONS

Provider Travel Information

Personal Data						
Name		Street Address				
Specialty						
Daytime Phone		City				
Evening Phone		State		Zip		
Fax Number		E-Mail Address				
AAA#						

Airline Preferences	
Seating Preference	☐ Aisle ☐ Window
Special Requirements	

Frequent Flyer Numbers (Check for Preferred Airline)			
☐American		☐USAir	
☐America West		☐Southwest	
☐Continental		☐United	
☐Delta		☐Other	
☐Northwest		☐Other	

Car Rental Information					
☐Smoking			☐Non-Smoking		
Driver's License #		State of Issue		Expiration Date	

Emergency Contact Information					
Name		Street Address			
Relationship		City			
Phone		State		Zip	

Assignment Information			
Hospital		City, State	
Dates Working:		Preferred Travel Time:	☐ AM ☐ PM ☐ Any

Please return to Robbyn Davis at Robbyn.Davis@LocumConnections.com or via fax at 678-441-8623

LOCUMCONNECTIONS

DIRECT DEPOSIT FORM

Worker Instructions:

1. Complete the "**WORKER - Required Information**" **section**.
2. Complete the **Direct Deposit section** to specify where you want your pay deposited.
3. **ATTACH A VOIDED CHECK with the form (for each bank account your enter!**
4. **SIGN** the bottom of the form.
5. Fax **completed/signed form** AND **voided check(s)** to Hospitalist Connections Payroll. Retain a copy of this form for your records.

1. Worker - Required Information

Please Print

a. **Worker Name** _____

b. **Last 4 Digits of Social Security #** XXX - XX - ____ ____ ____ ____

c. **If being paid as business (LLC, Corp – DBA (*Doing Business As*):** *(if **NOT** – ignore this section [1 c.])*

Please enter Business Name (as shown on W-9): _____

Last 4 Digits of Federal ID# (as shown on W-9): XX – XXX ____ ____ ____ ____

2. Complete for Direct Deposit and Sign Below

I authorize Hospitalist Connections to deposit my wages/salary *(and exp. reimbursements, if applicable)* to the following bank accounts:

Bank Account # 1

☐ **Checking**

Bank Name _____

☐ **Savings**

Bank Name _____

☐ **Bank Card Option** (if you do not have a bank account)

Please ask Human Resources for an application.

I wish to deposit (check one):

☐ Remainder of Net Pay (or 100% - total pay)

☐ _____% of Net

☐ Specific dollar amount $_____.00

3. Please attach one of the following for Checking or Savings accounts (check one):

☐ Voided check (*usually best option*)

☐ Deposit slip (**ONLY** accepted if the verbiage "ACH R/T" appears before the routing number)

☐ Bank letter or specification sheet (signature of your local bank representative MUST be included)

Bank Account # 2

☐ **Checking**

Bank Name _____

☐ **Savings**

Bank Name _____

I wish to deposit (check one):

☐ Remainder of Net Pay (or 100% - total pay)

☐ _____% of Net

☐ Specific dollar amount $_____.00

3. Please attach one of the following for Checking or Savings accounts (check one):

☐ Voided check (*usually best option*)

☐ Deposit slip (**ONLY** accepted if the verbiage "ACH R/T" appears before the routing number)

☐ Bank letter or specification sheet (signature of your local bank representative MUST be included)

Bank Account # 3 and more

☐ *If you are interested in using more than 2 banks – check here – and request paperwork to enter additional choices.*

4. Worker Signature _____ **Date** ____ ____ / ____ ____ / **20** ____ ____

By signing above, I am agreeing that I am either the accountholder or have the authority of the accountholder to authorize my employer to make direct deposits into the named account.

Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶
☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here **Signature of U.S. person ▶** **Date ▶**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules for partnerships* on page 1.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). Check the "Limited liability company" box only and enter the appropriate code for the tax classification ("D" for disregarded entity, "C" for corporation, "P" for partnership) in the space provided.

For a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line.

For an LLC classified as a partnership or a corporation, enter the LLC's name on the "Name" line and any business, trade, or DBA name on the "Business name" line.

Other entities. Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note. You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the "Exempt payee" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),

2. The United States or any of its agencies or instrumentalities,

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or

5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,

9. A futures commission merchant registered with the Commodity Futures Trading Commission,

10. A real estate investment trust,

11. An entity registered at all times during the tax year under the Investment Company Act of 1940,

12. A common trust fund operated by a bank under section 584(a),

13. A financial institution,

14. A middleman known in the investment community as a nominee or custodian, or

15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 7[2]

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, and payments for services paid by a federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at *www.ssa.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting *www.irs.gov* or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt payees, see *Exempt Payee* on page 2.

Signature requirements. Complete the certification as indicated in 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or disregarded entity owned by an individual	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Disregarded entity not owned by an individual	The owner
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

Call the IRS at 1-800-829-1040 if you think your identity has been used inappropriately for tax purposes.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov.* You may also report misuse of the IRS name, logo, or other IRS personal property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: *spam@uce.gov* or contact them at *www.consumer.gov/idtheft* or 1-877-IDTHEFT(438-4338).

Visit the IRS website at *www.irs.gov* to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. possessions to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.