Credentials Verification & Quality Assurance Packet

Interim Physicians is a leading provider of physician staffing services. Since our beginning in 1979 we have specialized in short and long-term physician locum tenens with unmatched benefits for you. The Interim Physicians team of professionals is trained to provide you with interesting assignments, competitive compensation, a quick registration process and a smooth transition to your new location. We also provide you with the most up-to-date information on industry trends, practice management, and clinical data to enhance your career.

Our enclosed credentials packet is a vital link to our A+ rated malpractice insurance carrier. These simple forms provide the information we need to speed the internal and hospital background process and enables us to pursue licensure in other states on your behalf, should you desire to do so.

Here is a short list of what we will need from you:

- A current CV (including the months for the last 5 years and explain any gaps in work history)
- A minimum of 3 reference names (telephone numbers and fax numbers or email addresses, if possible)
- Completed Interim Physicians, LLC registration form
- W-9 form (completely filled out and signed)
- NPDB Self-Query (Only if “Yes” answers to Questions 2 and/or 4 of the Presentation Questions)
- Specialty board certificate(s)
- Residency certificate
- Internship certificate
- Medical school diploma
- ECFMG certificate (If applicable)
- DEA certificate
- State licensure certificates and wallet cards certifying current registration
- State controlled substance registration (if applicable)
- BLS/ACLS/ATLS/PALS certification cards

Return:

Please fax a copy of the completed packet and supporting documentation to (800) 505-4794, or email to qa@interimphysicians.com.

For additional questions or comments, please call (800) 226-6347

www.interimphysicians.com
(800) 226-6347

Physician Registration Form

Specialty

Identifying Information	Last Name	First Name	Initial	Cell Phone	
	Home Address	Social Security Number		Home Phone	
	City	State		Zip	
	Birthplace	Citizenship	Visa Status		Date of Birth
	Weeks per year you would like to work?	Federal DEA #		Expiration Date	ECFMG
	Geographic Preferences:				
	Email Address:	NPI Number:			
	Please list all Institutions attended. (Use a separate sheet if necessary.)				
Premedical Education	School		Dates Attended (from) (to)		Degree
	Street	City		State	Zip
Medical Education	School		Dates Attended (from) (to)		Degree
	Street	City		State	Zip
Other Graduate Education	School		Dates Attended (from) (to)		Degree
	Street	City		State	Zip
Internship	School		Dates Attended (from) (to)		Specialty
	Street	City		State	Zip
Residency	School		Dates Attended (from) (to)		Specialty
	Street	City		State	Zip
Fellowship	School		Dates Attended (from) (to)		Specialty
	Street	City		State	Zip
Certification	Board Certifiedyes	? American Board of:	Date Certified	Date Re-Certified	Expiration Date
	Additional Board Certification:	American Board of:	Subspecialty Certified:		
	Board Eligible? yes no	Other Certifications:	BLS/Exp Date	ATLS/Exp. Date	ACLS/Exp. Date	PALS/Exp. Date

References	**Please list a minimum of four professional references. They must be able to attest to your specific medical abilities and have worked with you in the past 2 years.**			
	Name			Relationship
	Specialty		Phone	Fax or Email
	Name			Relationship
	Specialty		Phone	Fax or Email
	Name			Relationship
	Specialty		Phone	Fax or Email
	Name			Relationship
	Specialty		Phone	Fax or Email
	Name			Relationship
	Specialty		Phone	Fax or Email
Licenses	**Please list all active state medical licenses, using a separate sheet if necessary.**			
	State	Number	Issue Date	Exp. Date
	State	Number	Issue Date	Exp. Date
	State	Number	Issue Date	Exp. Date
	State	Number	Issue Date	Exp. Date
	State	Number	Issue Date	Exp. Date
	In which state did you obtain your original license?			
	Please list all state controlled substance licenses:			
	Please list all inactive licenses:			
Memberships	**List professional memberships in Local, State and National Societies**			

Please ensure that your CV work history lists month and year for each activity and includes an explanation for any gap in employment or schooling greater than one month.

I certify that the information on this registration is true and complete to the best of my knowledge. I authorize Interim Physicians, LLC to release information contained in this registration, or obtained by Interim Physicians, LLC pursuant to its credentials verification processes also authorized by this paragraph, to its Clients, and to query the DEA, AMA, FACIS, FSMB, insurance companies, and medical facility clients. I waive any claims I might otherwise have against Interim Physicians, LLC for releasing information as authorized by this paragraph.

Signature: _____ Date: _____

Physician Work History

Please list in chronological order all institutions (including hospitals, corporations, military assignments or government agencies) with which you have been affiliated since completion of post-graduate training.

Hospital Name City/State	Employer or Group	Job Title	From Date	To Date

Release Authorization Form

I hereby authorize the following individuals and entities to release all information (documented, oral or other) about me in their possession to Interim Physicians, LLC or its agents:

1. All hospitals at which I have ever held privileges, whether full or limited, temporary or permanent; and all hospitals at which I have ever received training.
2. All medical/osteopathic societies, education institutions, specialty boards, and other medical/osteopathic organizations with which I have been associated.
3. All other State or Canadian licensure boards, including the Federation of State Medical Boards, federal health agencies, and federal and state drug control agencies.
4. All licensed physicians, nurses or other health care professionals of any state or Canadian province.
5. All attorneys who have participated in civil or criminal actions in which I was named party.

I hereby release the above named individuals and entities from all liability for the release of information to Interim Physicians, LLC and its agents. I further release from liability any group or individual that provides information relating to my ability as a healthcare professional. I authorize Interim Physicians, LLC to release information as needed to facilities, entities and medical organizations in the process of pursuing work in my profession and/or obtain hospital privileges, licensure or other medical professional qualifications on my behalf.

I further authorize Interim Physicians, LLC or any of its duly authorized agents to make any investigations that they deem necessary to secure information concerning me which is relevant to the requirements for credentialing, and I further authorize them to release such information they now or in the future have concerning me to (i) any federal, state, county, or local governmental entity, (ii) any hospital or other health care facility, or (iii) any other person upon a showing that the release of this information is vital to the health, safety and welfare of the general public.

_____ _____

Print Name (Provider) Signature (Provider)

_____

Date

Background Check Authorization Form

Interim Physicians, LLC. (the "Company") will procure a consumer report and/or investigative consumer report on you in connection with your application for contract position purposes (including employment, volunteer, or independent contractor assignments, as applicable) as defined under the Fair Credit Reporting Act. These background reports may be obtained at any time after receipt of your authorization and, if you are hired or engaged by Interim Physicians, LLC., throughout your contract period.

TalentWise Solutions LLC, a consumer reporting agency, will obtain the report for Interim Physicians, LLC. TalentWise Solutions is located at 19800 North Creek Parkway, Suite 200, Bothell, WA 98011, and can be reached at (866) 338-6739.

The report may contain information bearing on your character, general reputation, personal characteristics, mode of living. The information that may be included in your report include: social security number trace, criminal records checks, public court records checks, driving records checks, educational records checks, verification of employment positions held, personal and professional references checks, and licensing and certification
checks. The information contained in the report will be obtained from private and/or public record sources. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for contract position is an investigation into your education and/or employment history.

Provided to you with this authorization is a Summary of Your Rights Under the Fair Credit Reporting Act in a form prescribed by the Federal Trade Commission. Please do not sign this authorization until you have received this summary.

AUTHORIZATION
I have carefully read and understand this disclosure and authorization form and I have received a copy of the Summary of Your Rights Under the Fair Credit Reporting Act provided with this form. I have had the
opportunity to review my rights. By my signature below, I consent to the preparation of background reports by TalentWise Solutions LLC, and to the release of such reports to Interim Physicians, LLC and its designated representatives for the purpose of assisting Interim Physicians, LLC in making a determination as to my eligibility for contract employment, contract assignment or for other lawful purposes.

I understand that I may be the subject of an investigative consumer report which may include information regarding my background. By my signature below, I consent to the preparation of background reports by TalentWise, and to the release of such reports to Interim Physicians, LLC and its designated representatives for the purpose of assisting Interim Physicians, LLC in making a determination as to my eligibility for contract assignments.

I understand that, to the extent allowed by law, information contained in my job application or otherwise disclosed to Interim Physicians, LLC by me before or during my contract assignment, if any, may be utilized for the purpose of obtaining such consumer reports and/or investigative consumer reports about me. I understand that nothing herein shall be construed as an offer of a contract for services. I hereby authorize law enforcement agencies, learning institutions(including public and private schools and universities), information service bureaus, record/data repositories, courts(federal/state/local), motor vehicle record agencies, my past or present employers, the military and other individuals or sources to furnish any and all information on me that is requested by the consumer reporting agency. By my signature (including electronic) below, I certify the information provided on and in connection with this form is true, accurate, and complete. I agree that this form in original, faxed, photocopied or electronic form will be valid for any background reports that may be requested by or on behalf of Interim Physicians, LLC.

This information is being collected to conduct the background screen on you. It will not be used for any other purpose.

Signature: _____ Date:

A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT

Para informacion en espanol, visite www.ftc.gov/credit o escribe a la FTC Consumer Response Center, Room 130-A 600 Pennsylvania Ave. N.W., Washington, D.C. 20580.
The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. For more information, including information about additional rights, go towww.ftc.gov/credit or write to: Consumer Response Center, Room 130-A, Federal Trade Commission, 600 Pennsylvania Ave. N.W., Washington, D.C. 20580.

- You must be told if information in your file has been used against you. Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- You have the right to know what is in your file. You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
- a person has taken adverse action against you because of information in your credit report;
- you are the victim of identity theft and place a fraud alert in your file;
- your file contains inaccurate information as a result of fraud;
- you are on public assistance;
- you are unemployed but expect to apply for employment within 60 days.

In addition, by September 2005 all consumers will be entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.ftc.gov/credit for additional information.

- You have the right to ask for a credit score. Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- You have the right to dispute incomplete or inaccurate information. If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.ftc.gov/credit for an explanation of dispute procedures.
- Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information. Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- Consumer reporting agencies may not report outdated negative information. In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- Access to your file is limited. A consumer reporting agency may provide information about you only to people with a valid need -- usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- You must give your consent for reports to be provided to employers. A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.ftc.gov/credit.
- You may limit "prescreened" offers of credit and insurance you get based on information in your credit report. Unsolicited "prescreened" offers for credit and insurance must include a tollfree phone number you can call if you choose to remove your name and address from the lists these offers are based on.

You may opt-out with the nationwide credit bureaus at 1-888-5- OPTOUT (1-888-567-8688).

- You may seek damages from violators. If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- Identity theft victims and active duty military personnel have additional rights. For more information, visit www.ftc.gov/credit.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. Federal enforcers are:

TYPE OF BUSINESS:	CONTACT:
Consumer reporting agencies, creditors and others not listed below	Federal Trade Commission: Consumer Response Center - FCRA Washington, DC 20580 1-877-382-4357
National banks, federal branches/agencies of foreign banks (word "National" or initials "N.A." appear in or after bank's name)	Federal Trade Commission: Consumer Response Center - FCRA Washington, DC 20580 1-877-382-4357
Federal Reserve System member banks (except national banks, and federal branches/agencies of foreign banks)	Federal Trade Commission: Consumer Response Center - FCRA Washington, DC 20580 1-877-382-4357
Savings associations and federally chartered savings banks (word "Federal" or initials "F.S.B." appear in federal institution's name)	Office of Thrift Supervision Consumer Complaints Washington, DC 20552 800-842-6929
Federal credit unions (words "Federal Credit Union" appear in institution's name)	National Credit Union Administration 1775 Duke Street Alexandria, VA 22314 703-519-4600
State-chartered banks that are not members of the Federal Reserve System	Federal Deposit Insurance Corporation Consumer Response Center, 2345 Grand Avenue, Suite 100 Kansas City, Missouri 64108-2638 1-877-275-3342
Air, surface, or rail common carriers regulated by former Civil Aeronautics Board or Interstate Commerce Commission	Department of Transportation , Office of Financial Management Washington, DC 20590 202-366-1306
Activities subject to the Packers and Stockyards Act, 1921	Department of Agriculture Office of Deputy Administrator - GIPSA Washington, DC 20250 202-720-7051

NEW YORK CORRECTION LAW
ARTICLE 23-A
New York Bus Code §380-c(b)(2) and 380-g(d)

§750. Definitions. For the purposes of this article, the following terms shall have the following meanings:

1. "Public agency" means the state or any local subdivision thereof, or any state or local department, agency, board or commission.
2. "Private employer" means any person, company, corporation, labor organization or association which employs ten or more persons.
3. "Direct relationship" means that the nature of criminal conduct for which the person was convicted has a direct bearing on his fitness or ability to perform one or more of the duties or responsibilities necessarily related to the license, opportunity, or job in question.
4. "License" means any certificate, license, permit or grant of permission required by the laws of this state, its political subdivisions or instrumentalities as a condition for the lawful practice of any occupation, employment, trade, vocation, business, or profession. Provided, however, that "license" shall not, for the purposes of this article, include any license or permit to own, possess, carry, or fire any explosive, pistol, handgun, rifle, shotgun, or other firearm.
5. "Employment" means any occupation, vocation or employment, or any form of vocational or educational training. Provided, however, that "employment" shall not, for the purposes of this article, include membership in any law enforcement agency.

S751. Applicability. The provisions of this article shall apply to any application by any person for a license or employment at any public or private employer, who has previously been convicted of one or more criminal offenses in this state or in any other jurisdiction, and to any license or employment held by any person whose conviction of one or more criminal offenses in this state or in any other jurisdiction preceded such employment or granting of a license, except where a mandatory forfeiture, disability or bar to employment is imposed by law, and has not been removed by an executive pardon, certificate of relief from disabilities or certificate of good conduct. Nothing in this article shall be construed to affect any right an employer may have with respect to an intentional misrepresentation in connection with an application for employment made by a prospective employee or previously made by a current employee.

S752. Unfair discrimination against persons previously convicted of one or more criminal offenses prohibited. No application for any license or employment, and no employment or license held by an individual, to which the provisions of this article are applicable, shall be denied or acted upon adversely by reason of the individuals having been previously convicted of one or more criminal offenses, or by reason of a finding of lack of ―good moral
character‖ when such finding is based upon the fact that the individual has previously been convicted of one or more criminal offenses, unless:

1. There is a direct relationship between one or more of the previous criminal offenses and the specific license or employment sought or held by the individual; or
2. the issuance or continuation of the license or the granting or continuation of the employment would involve an unreasonable risk to property or to the safety or welfare of specific individuals or the general public.

S753. Factors to be considered concerning a previous criminal conviction; presumption.
1. In making a determination pursuant to section seven hundred fifty—two of this chapter, the public agency or private employer shall consider the following factors:

a. The public policy of this state, as expressed in this act, to encourage the licensure and employment of persons previously convicted of one or more criminal offenses.
b. The specific duties and responsibilities necessarily related to the license or employment sought or held by the person.
c. The bearing, if any, the criminal offense or offenses for which the person was previously convicted will have on his fitness or ability to perform one or more such duties or responsibilities.
d. The time which has elapsed since the occurrence of the criminal offense or offenses.
e. The age of the person at the time of occurrence of the criminal offense or offenses.
f. The seriousness of the offense or offenses.
g. Any information produced by the person, or produced on his behalf, in regard to his rehabilitation and good conduct.
h. The legitimate interest of the public agency or private employer in protecting property, and the safety and welfare of specific individuals or the general public.

2. In making a determination pursuant to section seven hundred fifty—two of this chapter, the public agency or private employer shall also give consideration to a certificate of relief from disabilities or a certificate of good conduct issued to the applicant, which certificate shall create a presumption of rehabilitation in regard to the offense or offenses specified therein.

S754. Written statement upon denial of license or employment. At the request of any person previously convicted of one or more criminal offenses who has been denied a license or employment, a public agency or private employer shall provide, within thirty days of a request, a written statement setting forth the reasons for such denial.

S755.Enforcement.
1. In relation to actions by public agencies, the provisions of this article shall be enforceable by a proceeding brought pursuant to article seventy—eight of the civil practice law and rules.
2. In relation to actions by private employers, the provisions of this article shall be enforceable by the division of human rights pursuant to the powers and procedures set forth in article fifteen of the executive law, and, concurrently, by the New York city commission on human rights.

Physician Qualification Form

Check **Yes** or **No** next to each question. Provide explanations for **Yes** answers in a separate document.

Y	N		
☐	☐	1.	Has your medical license in any state ever been limited, denied, suspended, revoked, or surrendered, or have you ever received disciplinary actions of any kind on any license?
☐	☐	2.	Have your privileges at any hospital ever been suspended, limited or revoked (even if they were subsequently reinstated)?
☐	☐	3.	Have you ever been denied membership or renewal thereof or been subject to disciplinary action by any medical organization?
☐	☐	4.	Have you ever been involved, directly or indirectly, in a claim, potential claim or suit arising out of the rendering or failing to render professional services (even if the suit was subsequently dropped or dismissed)?
☐	☐	5.	Do you currently have any potential claims or suits, or are you aware of any claims or suits pending, rising from the rendering or failing to render of professional services?
☐	☐	6.	Has your professional liability insurance ever been denied, canceled or renewal refused?
☐	☐	7.	Has your DEA certificate ever been denied, canceled, or renewal refused?
☐	☐	8.	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)?
☐	☐	9.	Have you ever been the subject of an investigation by any private, federal, or state agency concerning your participation in any private, federal or state health insurance program?
☐	☐	10.	Have you ever been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program?
☐	☐	11.	Have you ever been addicted to a controlled substance that has affected your ability to perform the duties of a physician?

I certify that this information is true and complete to the best of my knowledge.

_____ _____

Print Name (Provider) Signature (Provider)

_____

Date

NPDB Self-Query Process

To start the process go to: http://www.npdb.hrsa.gov/

What will I need?

- Identifying information, professional school, and license
- Credit card for the $5.00 fee
- Email address

How long will it take?

It takes most people an average of 25 minutes to fill out the form. If you verify your identity online, in most cases a response will be ready within a few minutes. However, if you are unable to verify online, you will need to have your form notarized and mail it to the Data Bank, which may take a week or more.

Note: If you do not use your own credit card, you will not be able to verify your identity online.

How will you verify my identity?

You can verify your identity by answering financial based questions that only you would know. If you cannot answer these questions you must visit a notary public to witness your signing and dating the "Individual Self-Query" form that attests to your identity. Using a notary requires you to mail the signed form to the Data Bank.

What will I get?

Once your identity is verified and your self-query has been processed, you will be able to view your response online and a paper copy will be mailed to you.

Step By Step Process:

- Select Start a Self-Query on an Individual (Search on Myself)
- Acknowledge & Agreement page, select continue
- Go through the 4 steps
    - Subject Information
    - Output Options
    - Payment Information
    - Verify Your Identity
    - Print

Locum Tenens Provider Agreement
Agreement

This is an Agreement between Interim Physicians, LLC, a Delaware limited liability corporation, d/b/a Interim Physicians ("Interim" or "Broker"), with its principal place of business at 12140 Woodcrest Executive Drive, Suite 310, St. Louis, MO 63141, and the Provider described below ("Provider"), to provide locum tenens medical services at the assignment address and for the rates and periods described in Addendums and Exhibits provided for herein, subject to the terms of this agreement.

1. PROVIDER INFORMATION

Contractor Name:	
Remit To Address:	
City, State, ZIP:	
Phone Number:	

2. RATE INFORMATION

Broker's payment to Provider will be shown as a separate Exhibit A for each assignment accepted and will become a part of this Agreement. For each assignment agreed upon between Broker, a client of Broker ("Client") and Provider, an Exhibit A will be generated by Broker and delivered to Provider. A facsimile or email transmission of either a manually or electronically signed Provider Agreement or Exhibit A shall be sufficient for all purposes. The Exhibit A shall identify the Client's location of the assignment that requires the services of Provider, the Provider's corresponding payment and the corresponding dates of the assignment. The payment provisions of Exhibit A shall be binding. The provisions of this Agreement will apply to each Exhibit A except in case of conflict between terms, in which event the Exhibit A shall control as to the particular assignment involved.

3. BROKER RESPONSIBILITIES

Broker agrees:

a. To use its best efforts to provide acceptable locum tenens assignment(s).
b. To provide medical malpractice liability insurance on behalf of Provider through such carrier as is then providing coverage to all of the independent contractor physicians of Broker.
c. To coordinate between Provider and Client the round-trip transportation, lodging and local transportation necessary for the placement of Provider hereunder.

4. PROVIDER RESPONSIBILITIES

Provider agrees:

a. To provide medical services in accordance with the policies, procedures and medical staff bylaws in effect in the client's facility or facilities in which Provider provides such services, including, but not limited to, maintaining proper and appropriate medical records and/or signing all appropriate reports in a timely manner.
b. To promptly provide Broker with all information and documentation requested by Broker or Client.
c. Except as provided in paragraph 3(c) of this Agreement, or as otherwise agreed to in writing by Broker or Client and signed by an authorized representative, to pay for all of Provider's additional expenses, including, but not limited to, upgrades on all airline, lodging, and ground transportation, food, and personal telephone and entertainment costs.
d. On Monday of each week during the term of this Agreement, to email or fax to Broker a weekly Provider Statement of Work Performed ("Work Log") along with a copy of receipts in support of approved expenses

for the week, signed by an authorized representative of Client. Provider acknowledges and agrees that Broker shall not be obligated to make any payment to Provider for any period for which Broker has not received both an approved Work Log, signed by an authorized representative of Client, and copies of receipts for valid expenses.

e. To indemnify, defend and hold harmless Broker, its respective officers, employees, agents and affiliates, from and against any and all liability, loss, cost and expense (including, without limitation, reasonable attorney's fees) arising out of or in connection with Provider's negligent acts or omissions that are not covered by Broker's medical malpractice liability insurance.
f. All payment for Provider's services hereunder (except the fees payable to Provider by Broker pursuant to any subsequent Exhibit A) shall be the property of Client. Should Provider receive payments as a consequence of Provider's services to client hereunder, Provider hereby irrevocably authorizes Client to endorse and deposit checks and other instruments made payable to the Provider for such services. Provider further agrees to deliver written evidence of assignment of fees and the authority herein granted to such Medicare or Medicaid carrier, government agency or entity, bank or other party as maybe designated by Client or by any facility of Client at which medical services are performed by Provider hereunder.
g. That the terms of this Agreement, and Provider's engagement hereunder, are confidential, and, except as required by law, Provider shall not, directly or indirectly, without the prior written consent of Broker, disclose the terms of this Agreement or Provider's assignment hereunder, to any third party.
h. To provide Client, via Broker's representative, with no less than 30 days' notice before canceling any arranged, scheduled or ongoing locum tenens assignment, whether verbal or written. In the event such notice is not forthcoming, Provider agrees to pay any cost incurred by Broker or its Client pertaining to credentialing, transportation, lodging, mailing and facsimile but only those expenditures that result from Provider's promise, verbal or written, to perform such scheduled shifts.

5. NON-COMPETITION PROVISION

During the term of this Agreement and for a period of two (2) years after the formal termination of this Agreement, provider agrees not to accept an offer of employment from either another agency or the Client directly to work on a contract basis or as an employee (either part time, full time, or as an Independent Contractor) at a Client facility where the Provider performed medical services under the terms of this Agreement; or to which Provider's Curriculum Vitae (CV) was presented due to the efforts of Interim, without the expressed written consent of Interim.

6. TERMS OF AGREEMENT

This Agreement shall take effect upon the execution hereof and shall continue until the earlier of:

a. The refusal of Broker's medical malpractice insurer to provide coverage to Provider or the cancellation of Provider's insurance coverage by such carrier.
b. The material misrepresentation or willful omission from any curriculum vitae or credentialing documents provided by Provider to Broker, or
c. The loss by Provider of any license, certification or privilege required for the delivery by Provider of medical services hereunder.

7. GENERAL

Provider and Broker agree:

a. Any notice provided for in this Agreement shall be in writing and shall be sent to the President of Interim or to Provider at the addresses shown on the attachment to this Agreement or to such other address as either party may from time to time specify by notice to the other party.
b. Provider shall immediately notify Client and Interim in writing of any threatened or actual malpractice claims involving Provider, whether the situation giving rise to such claims took place before or during this Agreement or related to professional services in connection with this Agreement; Provider also agrees to notify Interim immediately via a written Incident Report relating to services provided under

this Agreement that Provider has any reason to believe may lead to a malpractice claim, including any notification of such possible action from any healthcare facility. Provider understands and accepts that failure to comply with the terms of this paragraph may invalidate the malpractice liability insurance provided under this Agreement.

c. Anything in the Agreement to the contrary notwithstanding, Interim shall not have or exercise any control of any kind or nature over the manner or means by which Provider performs medical services or makes medical judgments or determinations, nor shall any provision of this Agreement be deemed or construed to mean that Interim, or any employee of Interim, is engaged in the practice of medicine.

d. Any dispute or disagreement arising out of or relating to this Agreement shall be resolved by binding arbitration conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association. The award of the arbitrator(s) may be entered and enforced in any court of competent jurisdiction.

e. This Agreement: (1) constitutes the entire agreement of the parties with respect to the subject matter hereof; (2) may not be amended, altered or revised, except by instrument in writing, signed by both parties; (3) shall be binding upon the parties, their heirs, personal representatives, successors and assigns; (4) is severable, and if any provision shall be deemed to be invalid or unenforceable, such determination shall not affect the validity or enforceability of any other provision of this Agreement; (5) shall be deemed to be a contract made and entered into under the laws of the State of Missouri and the laws of such State shall govern the interpretation and enforcement hereof.

f. The provisions of Section 4 (g) and (h) shall survive the termination or expiration of this Agreement.

8. INDEPENDENT CONTRACTOR STATUS **INITIALS_____**

Provider and Broker agree that Provider, Client and Interim are independent entities. Without limiting the generality of the foregoing, Provider specifically acknowledges and agrees that Provider is not an employee of Interim. Provider shall be responsible for the payment of all income, Social Security, Medicare, self-employment and other taxes, federal, state and local, due upon the amount paid to Provider pursuant to this Agreement, and that no such taxes shall be paid or withheld by Interim. Interim may request that Provider show proof that all appropriate tax forms have been filed or paid with the appropriate taxing authorities. Provider agrees to procure, keep and maintain state statutory limits for workers compensation and unemployment insurance to the extent applicable for Independent Contractors. Provider warrants and agrees that Provider is not eligible for such benefits from Broker or Client.

Provider also acknowledges and agrees that, in accordance with the generally accepted definition of an Independent Contractor, assignments may be terminated at will by Client, with cause or without cause at the Client's discretion, and that this Agreement will constitute the only agreement between the parties.

Provider further acknowledges that, as a consequence of this Agreement, and the services provided by Provider hereunder or upon the termination of this Agreement, he/she is not entitled to any benefits from Interim of any kind, including but not limited to: vacation pay, unemployment benefits or worker's compensation benefits.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date shown opposite their respective signatures.

THIS CONTRACT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

Provider: **Interim Physicians**

By: _____ By: _____

Date: _____ Date: _____

Please fax to Interim Physicians at (800) 859-3163

www.interimphysicians.com
(800) 226-6347

Vendor ACH Enrollment Form

To participate in Interim Physicians, LLC's ACH program:

1. Fill in the requested information
2. Attached voided check(s) for verification of bank information
3. Sign the form and return to Interim Physicians, LLC Accounting Department, either by:
    a. Fax: (800) 865-3564, or
    b. Email: accounting@interimphysicians.com

Vendor Name:	
Federal Taxpayer ID #:	
Phone Number:	

CHECK ONE OF THE FOLLOWING:

☐ New authorization ☐ Changing bank(s) ☐ Cancel ACH enrollment
☐ Changing ACH amount

Bank Information

Bank Name:	
Bank Phone:	
ABA/Routing #:	
Account #:	
Account Type	☐ Checking ☐ Savings

PLEASE CALL YOUR BANK TO VERIFY ABA/ROUTING AND ACCOUNT NUMBERS

I authorize Interim Physicians, LLC and the bank named above to deposit funds directly to the account(s) listed above. I further authorize Interim Physicians, LLC to make any adjustments for deposit errors which may occur (including withdrawal of funds from my bank account(s) in the case of overpayment). This authority will remain in effect until it is canceled in writing.

Signed_____Date_____

ATTACH VOIDED CHECK HERE