Thank you for allowing Millenia Physician Placement, LLC to assist you in your endeavors as a locum tenens physician. We are excited to welcome you to our team! Please complete the following items below so that we can begin the credentialing process.

Please complete the following documents to be returned to us along with your credentials.

- ☐ contract
- ☐ application (Please include professional experience for the past 5 years)
- ☐ disclosure form
- ☐ W-9
- ☐ I-9
- ☐ direct deposit form
- ☐ mammography packet (if applicable)
- ☐ reference form

Please provide us with the following documents:

- ☐ copy of Curriculum Vitae (*please include locum assignments worked and an explanation of gaps in your work history, if any)*
- ☐ copy of medical degree(s)
- ☐ copy of internship/residency certificate
- ☐ copy of board certification
- ☐ copy of ECFMG certificate (if applicable)
- ☐ copy of DEA certificate
- ☐ copies of all active state licenses
- ☐ copy of State Narcotics certificate (if applicable)
- ☐ copies of all valid CPR certification cards
- ☐ current photo (must be original)
- ☐ copies of 26 CME credits w/in past year
- ☐ statement of past and current legal actions (If none, please indicate)

CONTRACT – NON EMPLOYEE

This AGREEMENT is between Millenia Physician Placement, LLC ("Millenia Medical") and ______________________________
Name
("Physician") to provide locum tenens assignments for the Physician through the placement services of Millenia Medical with medical healthcare providers ("Client").

1. **RELATIONSHIP OF THE PARTIES:**
   1.1 The relationship of the Physician to Millenia Medical shall be that of an independent contractor.
   1.2 Physician agrees, as an independent contractor, to be completely responsible for his or her own appropriate self-employment tax payments, including Social Security payments, as well as any other required tax payments.

2. **DUTIES OF THE PARTIES:**

   Millenia Medical

   2.1 If Client cancels assignment without prior notice, Millenia Medical will use their best efforts to secure other suitable work for Physician. Millenia Medical does not guarantee suitable assignments can be found nor can Millenia Medical guarantee the duration of any specific assignment.
   2.2 Millenia Medical will purchase the physician's medical malpractice liability insurance for each assignment. This coverage of $1,000,000 per occurrence and $3,000,000 aggregate per year will be provided through the Millenia Medical(claims made) group policy.
   2.3 Millenia Medical shall not provide any other insurance coverage including, but not limited to, any workers compensation insurance, general liability insurance of any other insurance other than the medical malpractice insurance described herein.
   2.4 Payment for services, travel, housing, meals and local transportation arrangements for each assignment will be noted in the Confirmation Letter which will be provided to the Physician for each assignment. The Physician hereby agrees that Millenia Medical may deduct or withhold from any form of compensation any unauthorized expenses incurred by Physician.
   2.5 Millenia Medical will use their best efforts to assist the Physician in obtaining state licensing, where needed.

   Physician

   2.6 Physician has the right to accept or reject any assignment offered by Millenia Medical.
   2.7 If Physician is not able to report to the scheduled assignment or will not be available to continue in an assignment that he or she has committed to, Physician agrees to provide Millenia Medical with at least thirty (30) days written notice.
   2.8 Physician's daily work schedule shall be established by mutual consent of the Physician and the Client, alone. Physician agrees to be available for overtime and will take call as required by Client, unless otherwise agreed upon in writing.
   2.9 Physician agrees to follow required standards of medical care, current specialty standards, if applicable, and the guidelines, statements, and hospital and/or healthcare provider by-laws where applicable.

3. **PHYSICIAN PAYMENT:**
   3.1 Payment for services shall be made by Millenia Medical to the Physician, as set forth in the Confirmation Letter for so long as services are provided. Payments will be made on a weekly basis.
   3.2 Millenia Medical will provide Physician with a weekly work log to record all hours worked, including overtime and call hours. A representative of Client authorized to approve payment for hours worked must sign this work log. Failure to have the work log signed may result in a delay of payment by Millenia Medical to Physician.
   3.3 In the event Client disputes the number of hours worked by the Physician, Millenia Medical has the right to withhold monies or compensation from Physicians next pay check for the hours being disputed only. In the event that Client fails to pay Millenia Medical for the hours being disputed, Millenia Medical shall have no obligation to pay such physician for the hours in questions. If, and only when, Client pays Millenia Medical for the hours in question shall Millenia Medical have an obligation to pay the Physician for those hours.

____
Initials

4. **NON-SOLICITATION:** Physician shall not solicit or accept either a temporary assignment or permanent position or offer his or her curriculum vitae to the Client that Physician has been referred to by Millenia Medical, without written consent of Millenia Medical for a period of two (2) years after the agreement is terminated. Once Physician has provided services for a Millenia Medical Client, Physician may not provide services for said client through another placement company or by direct arrangement for a two (2) year period unless written arrangements have been made between Millenia Medical and Client to provide compensation to Millenia Medical.

5. **GOVERNING LAW:**
   5.1 This agreement shall be governed by and construed with the laws of the State of South Carolina and any dispute concerning this agreement shall be brought in a court of jurisdiction in Charleston, Charleston County, South Carolina.
   5.2 All communication required hereunder or by law may be in writing and shall be sent by registered or certified mail, return receipt requested, to the address listed below.

6. **ATTORNEYS FEES COSTS:** In the event that Millenia Medical secures the services of an attorney to collect any sums or enforce any other obligations owed to it under this contract, Millenia Medical shall be entitled to recover reasonable attorney's fees.

7. **ENTIRE AGREEMENT:** This instrument contains the entire agreement of the parties and may not be changed orally but only by an agreement in writing and signed by the party against whom enforcement of any waiver, change, modification, extension or discharge is sought.

8. **TERMINATION:** Millenia Medical and Physician shall have the right to cancel this agreement in writing without prior notice, except as otherwise provided herein.

9. **CONFIDENTIALITY:** The terms of this agreement may not be released to any third party, except the attorneys and accountants of Millenia Medical and Physician, without written consent of the other party.

IN WITNESS WHEREOF, the undersigned have caused this Agreement to be executed on the date shown below.

______________________ **(Provider Name)**	**Millenia Physician Placement, LLC**
By: ______________________ Signature	By: ______________________ Signature
______________________ Print Name	Melinda Chapman, VP of Physician Department Print Name
______________________ Address	7171 Highway 6 North, Suite 225 Houston, Tx 77095 Address
______________________ Date	______________________ Date

To provide quality malpractice insurance coverage, we request that you do the following when completing the malpractice application:

- Make sure that every blank has been completed
- Do not write in “See CV/Resume” as a place of referral.
- If any sections do not apply to your specialty, please write “N/A”
- Do not leave **any** spaces blank. When attaching documents to support documentation, please write “See Attached”
- Complete employment history with facility name, address, and contact number
- Sign as required throughout the application

IMPORTANT!!!

Please make sure that your CV/Resume is up to date including all work history. If there are any blanks, this will delay your credentialing process.

Thank you for your cooperation with this matter!

ANESTHESIOLOGY APPLICATION

INSTRUCTIONS: Please complete all sections and sign. If a section does not apply, please indicate by answering "N/A". If additional explanations are provided please write "See Attached" and include the documentation. Do not answer a section with "See CV"

PERSONAL INFORMATION

Full Name: ______________________________ Maiden (if applicable): ____________________
Last First Middle Initial
DBA: ______________________________ SS#: ____________________
Home Address: ____
Mailing Address: ____
Phone: (____) ____________ (____) ____________ (____) ____________ (___) ____________
Home Cell Pager Office
E-Mail: ______________ Place of Birth: ______________ Date of Birth: ______________
Emergency Contact: ______________ ______________ (___) ______________
Name Relationship Phone
______________ ______________ (___) ______________
Name Relationship Phone

LICENSURE INFORMATION

Name of State	% of Practice	Date Issued	Expiration Date	License Number
Name of State	% of Practice	Date Issued	Expiration Date	License Number
Name of State	% of Practice	Date Issued	Expiration Date	License Number
Name of State	% of Practice	Date Issued	Expiration Date	License Number
Name of State	% of Practice	Date Issued	Expiration Date	License Number

U.P.I.N.: ______________ Medicare #: ______________ Medicaid #: ______________
Narcotics License (DPS) # & State: ______________ Date Issued: ________ Expiration Date: ________
D.E.A. #: ______________ Date Issued: ________ Expiration Date: ________
Are you currently on a Radioactive Material License? If so, please provide us with a copy or a contact person to obtain information from. ______________

Please note all states where you have inactive or past licensure and state the reasons why.

State	License Number	Expiration Date	Reason for non-renewal

Initials

WORK HISTORY

*List all past and present affiliations. Attach separate sheet if necessary.

Facility	Address	Phone	Position	Dates
______________________	______________________________	_______________	___________	________
______________________	______________________________	_______________	___________	________
______________________	______________________________	_______________	___________	________
______________________	______________________________	_______________	___________	________
______________________	______________________________	_______________	___________	________

May we verify all work history? ☐ YES ☐ NO

If no, please let us know who not to contact and why.

Have you worked locum tenens before? ☐ YES ☐ NO

If yes, what agency did you work with? ____

If yes, please list facility, location, phone and dates or attach a list.

CERTIFICATIONS

- *Certifications*

	Certified?	Date of Certification
Name of certifying organization: ________________________________	☐ YES ☐ NO	_______________
Name of certifying organization: ________________________________	☐ YES ☐ NO	_______________

Have you ever taken an examination and failed to pass? ☐ YES ☐ NO (If yes, please provide explanation on separate page)

If not board certified, are you board eligible? ☐ YES ☐ NO (If yes, please note date of exam: ___________)

- *Mammo*

Are you MQSA Certified ☐ YES ☐ NO

If Yes, number of mammography reads for the last two years: ____

(Must read at least 960 total every 2 years)

- *Other Certifications*

Certification	Issue Date	Expiration Date	Instructor
☐ ACLS	________________	_________________	☐ YES ☐ NO
☐ BCLS	________________	_________________	☐ YES ☐ NO
☐ ATLS	________________	_________________	☐ YES ☐ NO
☐ PALS	________________	_________________	☐ YES ☐ NO

____

Initials

CERTIFICATIONS (Con't)

- CME (Please attach supporting documents)
  Please provide a listing of the required CME credit hours for licensure. You must provide proof of at least 26 CME credits for the past year. (If MQSA Certified, 15 of those must be breast CME credits.)

Course Title	Location	Dates	Hours

EDUCATION AND TRAINING

	School	City	State	Date Admitted	Date Completed	Degree
♦ UNDERGRADUATE:						
♦ UNDERGRADUATE:						
♦ GRADUATE/ MEDICAL SCHOOL:						

Did you graduate from a foreign school? ☐ YES ☐ NO
If yes, list ECFMG #: ________________________________

If you graduated from a foreign medical school but are not ECFMG certified, please explain why.

- INTERNSHIP *(Attach additional information if necessary.)*

Facility	Address	Dates	Specialty	Program Director
		From_____ To______		

- RESIDENCY

Facility	Address	Dates	Specialty	Program Director
		From_____ To______		
		From_____ To______		

- FELLOWSHIP (or additional training)

Facility	Address	Dates	Specialty	Program Director
		From_____ To______		
		From_____ To______		
		From_____ To______		
		From_____ To______		

SPECIALTY

Medical Specialty: ______________________ % of practice: ______________________
Sub-Specialty: ______________________ % of practice: ______________________

GENERAL HISTORY

Please provide a brief explanation below of all "YES" answers or attach a separate sheet if necessary.

		YES	*NO*
1.	Have you voluntarily or in voluntarily surrendered, limited or withdrawn your privileges anytime while under Peer investigation?	_____	_____
2.	Have you ever had a state license to practice medicine refused, suspended or revoked?	_____	_____
3.	Have you ever voluntarily surrendered or non-renewed a state license to practice medicine?	_____	_____
4.	Has membership in any professional association or society ever been revoked or refused?	_____	_____
5.	Has a hospital ever suspended, restricted or refused your staff privileges at any time while under peer Investigation?	_____	_____

6. Have you suffered from or been treated for a chronic illness or a physical defect for more than 30 days or are you suffering from or being treated for a chronic illness or a physical defect now? _____ _____
7. Have you ever been or are you currently being treated for mental illness including inpatient, outpatient or counseling? (If YES, provide details of rehabilitation program, including dates of treatment) _____ _____
8. Have you ever had counseling for mental therapy for more than 30 days or are you receiving counseling now? _____ _____
9. Have you ever taken psychiatric medications for more than 30 days or are you taking them now? _____ _____
10. Have you ever voluntarily surrendered or had a narcotics license refused, suspended, revoked or restricted? _____ _____
11. Have you ever been treated for alcoholism or narcotic addiction including inpatient, outpatient or counseling? _____ _____
(If YES, provide details of rehabilitation program, including dates of treatment)
12. Are you currently being treated for alcoholism or narcotic addiction including inpatient, outpatient or counseling? ____ _____
(If YES, provide details of rehabilitation program, including dates of treatment)
13. Have you ever been convicted of a felony? _____ _____
14. Has there been any significant changes to your practice in the past five years, (i.e., change of specialty, addition Or deletion of procedures? _____ _____

CONSENT

I hereby affirm and acknowledge that the information provided by me on this application and the attachments is true, complete and correct, and that Millenia Physician Placement, LLC will rely on the truthfulness of my statements in evaluating my potential to be placed with Millenia Medical's clients as a Locum Tenens physician. I further acknowledge that, as a condition precedent to my acceptance, a detailed inquiry and investigation of my background, competence and qualifications may be conducted by Millenia Medical or any subsidiary thereof. I hereby release Millenia Medical, its staff, representatives and agents from liability for their acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications. I further release from liability physicians, hospitals and other references for the good faith release of information regarding my professional capabilities and performances.

_______________________________ _______________________________
Signature Date

MALPRACTICE INSURANCE HISTORY (in addition to what Millenia Medical provides you with)

Current carrier name: _______________________________
Address: _______________________ Phone: (____) ____________ Fax: (____)____________
Policy Number: _______________________ Effective Dates: From ____________ to ____________
Limits/Coverage: $ _______________________ Tail Purchased?: _______________________

Any known open, pending or closed suits? ☐ YES ☐ NO
If yes, please provide additional information describing the incident that includes dates, payments and involvement on your behalf.

Past carrier name: _______________________________
Address: _______________________ Phone: (____) ____________ Fax: (____)____________
Policy Number: _______________________ Effective Dates: From ____________ to ____________
Limits/Coverage: $ _______________________ Tail Purchased?: _______________________

Any known open, pending or closed suits? ☐ YES ☐ NO
If yes, please provide additional information describing the incident that includes dates, payments and involvement on your behalf.

Past carrier name: _______________________________
Address: _______________________ Phone: (____) ____________ Fax: (____)____________
Policy Number: _______________________ Effective Dates: From ____________ to ____________
Limits/Coverage: $ _______________________ Tail Purchased?: _______________________

Any known open, pending or closed suits? ☐ YES ☐ NO
If yes, please provide additional information describing the incident that includes dates, payments and involvement on your behalf.

***NOTE:* PLEASE COMPLETE THE FOLLOWING FORM FOR ANY OPEN, PENDING, OR CLOSED SUITS/CLAIMS HISTORY NOT INCLUDED ABOVE OR BEYOND THE PAST 5 YEARS. CHECK THE BOX MARKED "NO" IF THIS INFORMATION DOES NOT APPLY.

MALPRACTICE HISTORY

- Are you aware of any circumstances that might lead to a potential claim or suit? ☐ YES ☐ NO
  (If YES, please explain) ____
  ____
  ____
  ____

- Has any claim or suit for alleged malpractice ever been brought against you? If so, please indicate how many. If none, please indicate. ☐ YES How many? ________ ☐ NO

  Name of Patient: ____
  Allegation: ____
  ____
  ____
  ____
  Your relationship to Patient (attending physician, surgeon, consultant, etc.): ____________
  ____
  Date of Incident: ____________________ Date Reported: ____________________
  Insurance Carrier at Time of Loss: ____
  Additional Defendants: ____
  Claim Status: _______ Open _______Closed
  If closed, indicate method of closing: ____ Dismissal ____ Settled _____ Judgment
  Date of Closing: ______________ Total amount of Settlement/Judgment: ______________
  Total amount of Settlement/Judgment on your behalf: ______________________

  (Describe your care and treatment of the patient. If additional space is necessary, use the back of this page or attach additional pages. Your must provide adequate clinical detail to allow proper evaluation by a committee of physicians and include the following information.)

  Condition and diagnosis at time of incident: ____
  ____
  ____

  Describe treatment rendered (include dates): ____
  ____
  ____

  Condition of patient subsequent to treatment (include dates): ______________________________
  ____
  ____

______________________	______________________	____________
Signature	**Printed Name**	**Date**

ANESTHESIA CAPABILITIES & PROCEDURES

Please note your level of competency by numbering each area 0 – 5 (0 indicates no experience and 5 indicates very experienced).

Anesthesia subspecialty including:

_______ Cardiac
_______ Pain
_______ Ob/Gyn
_______ ICU
_______ Thoracic
_______ Major Vascular
_______ Chronic pain evaluation (including diagnostic And therapeutic procedures
_______ Acute pain consultation & management (including The use of continuous intravenous, epidural, and Intraspinal analgesics.

Major regional anesthesia including:

_______ Cervical epidural
_______ Lumbar epidural
_______ Thoracic epidural
_______ Caudal anesthesia
_______ Subarachnoid anesthesia (spinal)

Minor regional anesthesia including:

_______ Intravenous regional anesthesia
_______ Selective minor nerve blocks (wrist,ankle,digital)

Symapthetic nerve blocks:

_______ Stellate ganglian
_______ Lumbar sympathetic
_______ Monitored anesthesia care
_______ Hypothermic anesthesia techniques
_______ Hypotensive anesthesia techniques
_______ Resuscitation (including emergency drug therapy)
_______ Fiberoptic laryngoscopy

Invasive monitoring techniques:

_______ Arterial lines
_______ Neo-natal anesthesia
_______ Central venous pressure lines
_______ Pulmonary artery catheters
_______ Ventilator management in post-op/intensive care setting
_______ Respiratory therapy consultation and/or supervision
_______ Pre-operative anesthetic consultations

General

_______ General inhalational anesthesia
_______General Intravenous anesthesia

Selective major nerve blocks including:

_______ Sciatic
_______ Axillary
_______ Femoral
_______ Interscalene

_______ Post-operative evaluation/ assessment
_______ Airway management
_______ Pediatric assessment
_______ Muscle relaxation management
_______ Post-operative anesthetic consulations

______________________	______________________	______________________
Signature	**Printed Name**	**Date**

DISCLOSURE STATEMENT AND AUTHORIZATION RELEASE

I hereby consent and give authority to the representatives of Millenia Physician Placement, LLC and all of its clients or customers, including hospitals, medical groups, clinics or doctors to obtain and review all records or other information that may be pertinent to the evaluation of my professional qualifications and competence to carry out services for Millenia Medical's clients. Additionally, I consent to representatives of Millenia Medical and all of its clients or customers, including hospitals, medical groups, clinics or doctors to conduct a personal and professional background reference check including verification of licensing and certifications, verification of education and transcripts and DEA/state narcotics license(s)/certification(s) and all other records or information concerning myself.

I hereby release Millenia Medical and all of its representatives from any liability from any and all of their activities conducted in connection with this authorization. Additionally, I hereby release from liability any and all individuals and organizations who provide information to Millenia Medical or its representatives, in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for provision of services to Millenia Medical clients, and I hereby consent to the release of any and all such information.

I UNDERSTAND THAT ANY SIGNIFICANT MISSTATEMENTS IN OR OMISSIONS CONTAINED IN MY APPLICATION, CONSTITUTES CAUSE FOR TERMINATION OR CONTRACT WITH MILLENIA MEDICAL OR CAUSE FOR CANCELLATION OF MILLENIA MEDICAL CONTRACT ASSIGNMENT. ALL INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE TO MY BEST KNOWLEDGE AND BELIEF.

______________________________ Name

______________________________ Date

______________________________ Signature

Attach photo here: (Mandatory)

PROFESSIONAL REFERENCES

Name: ____________________________

In order for Millenia Physician Placement, LLC to obtain professional references, please complete the following. Thank you.

Reference #1:
Name:________________________________ Address:________________________________
Home: (____) ____________________________ Work: (____) ____________________________
Pager: (____) ____________________________ E-mail: ________________________________

Reference #2:
Name:________________________________ Address:________________________________
Home: (____) ____________________________ Work: (____) ____________________________
Pager: (____) ____________________________ E-mail: ________________________________

Reference #3:
Name:________________________________ Address:________________________________
Home: (____) ____________________________ Work: (____) ____________________________
Pager: (____) ____________________________ E-mail: ________________________________

Reference #4:
Name:________________________________ Address:________________________________
Home: (____) ____________________________ Work: (____) ____________________________
Pager: (____) ____________________________ E-mail: ________________________________

Reference #5:
Name:________________________________ Address:________________________________
Home: (____) ____________________________ Work: (____) ____________________________
Pager: (____) ____________________________ E-mail: ________________________________

Reference #6:
Name:________________________________ Address:________________________________
Home: (____) ____________________________ Work: (____) ____________________________
Pager: (____) ____________________________ E-mail: ________________________________