



Thank you for allowing Millenia Physician Placement, LLC to assist you in your endeavors as a locum tenens nurse practitioner. 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-4 form
- I-9 form
- direct deposit form
- reference form (*please note physicians, PA's or NP's with whom you have had recent clinical contact with*)
- Health statement form

Please provide us with the following documents:

- copy of resume
- copy of Graduate Training Certificate or Graduate Degree
- copy of Certification/Re-Certification Card
- copies of current CME's
- copy of immunization records (PPD,MMR,Chest X-ray – if applicable)
- copies of all active state licenses
- copies of all valid CPR certification cards (if applicable)
- statement of past and current legal actions (If none, please indicate)



CONTRACT – EMPLOYEE

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

1. RELATIONSHIP OF THE PARTIES:

- 1.1 The relationship of the NP to Millenia Medical shall be that of an employee.
- 1.2 NP agrees, as an employee of Millenia Medical, taxes will be automatically deducted from each paycheck.

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 NP. 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 NP'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 NP for each assignment. The NP hereby agrees that Millenia Medical may deduct or withhold from any form of compensation any unauthorized expenses incurred by NP.
- 2.5 Millenia Medical will use their best efforts to assist the NP in obtaining state licensing, where needed.

Physician

- 2.6 NP has the right to accept or reject any assignment offered by Millenia Medical.
- 2.7 If NP 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, NP agrees to provide Millenia Medical with at least thirty (30) days written notice.
- 2.8 NPs daily work schedule shall be established by mutual consent of the NP and the Client, alone. NP agrees to be available for overtime and will take call as required by Client, unless otherwise agreed upon in writing.
- 2.9 NP 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 NP, 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 NP 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 NP.
- 3.3 In the event Client disputes the number of hours worked by the NP or complains to Millenia Medical concerning the quality of services rendered by NP, Millenia Medical has the right to withhold monies or compensation otherwise due to NP from Millenia Medical. In the event that Client fails to pay Millenia Medical because of a dispute over hours worked by a NP or because of the quality of services rendered by a NP, Millenia Medical shall have no obligation to pay such physician for the services. If, and only when, Client pays Millenia Medical shall Millenia Medical have an obligation to pay the NP.

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 NP 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 NP has provided services for a Millenia Medical Client, NP 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.

Initials

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 NP 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 NP, 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 following 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!



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"

IDENTIFYING 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
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

U.P.I.N.: _____ Medicare #: _____ Medicaid #: _____

Narcotics License (DPS) # & State: _____ Date Issued: _____ Expiration Date: _____

D.E.A. #: _____ Date Issued: _____ Expiration Date: _____

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

◆ Certification

Are you currently certified? YES NO Date of Certification: _____
Name of Certification: _____

Only answer if not currently certified:

Have you ever taken the national examination and failed to pass? YES NO
If yes, how many times? _____
Have you applied for the certification exam? YES NO
If yes, when are you scheduled to take the exam? _____

◆ Other Certifications

Certification	Issue Date	Expiration Date	Instructor
<input type="checkbox"/> ACLS	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> BCLS	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> ATLS	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> PALS	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO

CERTIFICATIONS (Con't)

- ◆ CME (Please attach supporting documents)
Please provide a listing of the required CME credit hours for licensure.

Course Title	Location	Dates	Hours
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

EDUCATION AND TRAINING

School	City	State	Date Admitted	Date Completed	Degree
◆ UNDERGRADUATE: _____	_____	_____	_____	_____	_____
◆ UNDERGRADUATE: _____	_____	_____	_____	_____	_____
◆ GRADUATE TRAINING: _____	_____	_____	_____	_____	_____

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.

MALPRACTICE INSURANCE HISTORY (Con't)

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

Name: _____

- ◆ 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

NP CAPABILITIES & PROCEDURES

Please rate your skills from 0 – 5, with 5 representing excellent and 0 representing no experience.

GENERAL:

- _____ Perform histories and physicals
- _____ Perform specialty physical exams/evaluations:
 - _____ Respiratory _____ Cardiovascular _____ Gastrointestinal
 - _____ ENT _____ Eye _____ Neurological
 - _____ Skeletal _____ Ob/Gyn _____ Genitourinary
 - _____ Pediatric
- _____ Counsel patients/significant others
- _____ Preventive Care:
 - _____ Diet _____ Activity _____ Physical Therapy
- _____ Observe vital signs
- _____ Urinary catheterizations:
 - _____ Male _____ Female
- _____ Apply and remove dressings and bandages
- _____ Administer injections:
 - _____ subcutaneous _____ intramuscular _____ intravenous
- _____ Draw venous blood samples
- _____ Draw arterial blood samples
- _____ Start intravenous fluids
- _____ Suture
- _____ Minor sprains and strains
- _____ Ingrown toenail removal
- _____ AIDS/HIV
- _____ Starting and maintaining IV's
- _____ Cell biopsy
- _____ Hypertension
- _____ Child abuse evaluation
- _____ Suicide and major depression
- _____ Seizures
- _____ Stroke and TIA's

EMERGENCY CARE/SITUATIONS:

- _____ Minor burns
- _____ Snake bites
- _____ Minor head injuries
- _____ Shock
- _____ Small open wounds
- _____ Cardiac arrest
- _____ Overdoses
- _____ Acute GI bleeding
- _____ Anaphylaxis
- _____ Chest pain

GENERAL SURGERY:

- _____ Assist in surgery
- _____ Care for superficial wounds
- _____ Suture minor surgical procedures
- _____ Close incision lines
- _____ Remove sutures/staples
- _____ Incise and drain superficial skin infections

- _____ Change dressings
- _____ Administer local infiltrative anesthetic
- _____ Perform nasogastric intubation

CARDIOLOGY:

- _____ Perform pulmonary function test
- _____ Screen results of EKG's
- _____ Screen results of treadmill tests
- _____ Perform cardiac stress testing
- _____ Perform cardioversion

GYNECOLOGY:

- _____ Perform gonorrhea cultures
- _____ Draw blood and order VDRL
- _____ Perform hemoglobin tests
- _____ Perform dipstick urine testing
- _____ Perform pregnancy tests
- _____ Perform microscopic urinalysis
- _____ Perform Chlamydia testing
- _____ Perform wet preps
- _____ Insert IUD's
- _____ Perform endometrial biopsies

ORTHOPEDICS:

- _____ Strap/cast/splint sprains and bones
- _____ Apply casts
- _____ Remove casts
- _____ Perform joint aspirations
- _____ Evaluation of common orthopedic injuries
- _____ Assist in surgery
- _____ Administer local infiltrative anesthetic
- _____ Inject musculoskeletal trigger points
- _____ Apply traction
- _____ Remove and/or adjust Garner-Wells tongs
- _____ Remove and/or adjust Halo traction
- _____ Bucks traction-application

ONCOLOGY:

- _____ Perform bone marrow biopsy
- _____ Administer chemotherapy
- _____ Declot central catheter

OTHER INVASIVE PROCEDURES:

- | | |
|---|--|
| _____ Arterial catheter insertion | _____ Incision & Drainage of abscesses |
| _____ Arterial & venous punctures | _____ Incision & Drainage of hematomas |
| _____ Thoracentesis | _____ Incision & Drainage of hemorrhoids |
| _____ Lumbar Puncture | |
| _____ Bladder aspiration by suprapubic needed | |
| _____ Levine gastric tube insertion | |
| _____ Arthrocentesis | |
| _____ Anoscopy | |

Signature

Printed Name

Date



DISCLOSURE STATEMENT AND AUTHORIZATION RELEASE

By my signature below, I authorize that 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 (Print)

Date

Signature



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: _____



HEALTH STATEMENT

Compliance Requirements

Name: _____ SS# _____ - _____ - _____
Last Name First Name

Immunizations:

MMR Immunization:	Date: _____	Results: _____
Rubeola Titer:	Date: _____	Results: _____
Rubeola Immunization:	Date: _____	Results: _____
Hepatitis B Titer:	Date: _____	Results: _____
Hepatitis B Immunizations:	Date: _____	
	Date: _____	
	Date: _____	
Varicella Titer:	Date: _____	Results: _____
Varicella Immunization:	Date: _____	
Chest X-Ray (optional)	Date: _____	
Mumps Titer:	Date: _____	
Physical Exam	Date: _____	

I have examined the above-named individual and found him/her to be in good health and free from communicable diseases.

Physician/Examining Practitioner:

Printed Name

Signature

Date

Address

Phone

