



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.

You will find the enclosed documents that are to be completed and returned.

- contract
- application (*Please include professional experience for the past 5 years*)
- disclosure form
- reference form
- mammography packet (***if applicable***)
- W-9
- I-9 (*Complete and return with copies of identification listed on page 2 of the I-9. Either one item from List A or one item each from List B & List C.*)
- direct deposit form (***if desired***)

Please provide us with the following documents:

- copy of Curriculum Vitae (*include an explanation of gaps in your work history, if any*)
- copy of medical degree(s)
- copy of internship/residency certificate
- copy of radioactive material license (***if applicable***)
- copy of board certification
- copy of ECFMG certificate (***if applicable***)
- copy of DEA certificate
- copies of all active state licenses
- copy of State Controlled Substance certificates (***if applicable***)
- copies of all valid CPR/Life Support certification cards
- current photo (*must be original*)
- copies of CME credits for the past three years
- statement of past and current legal actions (*If none, please indicate*)
- copy of NPDB Self Query from within the past 6 months



## **CONTRACT – NON EMPLOYEE**

This AGREEMENT is between Millenia Physician Placement, LLC (“Millenia Medical”) and \_\_\_\_\_ (“Physician”) to  
Name  
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.

<p>_____</p> <p>(Provider Name)</p> <p>By: _____</p> <p>Signature</p> <p>_____</p> <p>Print Name</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>Date</p>	<p><b>Millenia Physician Placement, LLC</b></p> <p>By: _____</p> <p>Signature</p> <p>Melinda Chapman, VP of Physician Department</p> <p>Print Name</p> <p>7171 Highway 6 North, Suite 225 Houston, Tx 77095</p> <p>Address</p> <p>_____</p> <p>Date</p>
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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!**



## RADIOLOGIST 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
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Name of certifying organization: _____	<input type="checkbox"/> YES <input type="checkbox"/> 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
<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

\_\_\_\_\_  
 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**

## RADIOLOGIST CAPABILITIES & PROCEDURES

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

### General

\_\_\_\_\_ Plain film studies

### CT

\_\_\_\_\_ Body

\_\_\_\_\_ Head

### Fluoroscopy

\_\_\_\_\_ G.I.

\_\_\_\_\_ Colon

\_\_\_\_\_ Urinary Tract

\_\_\_\_\_ Chest

\_\_\_\_\_ I.V. Pyleograms

\_\_\_\_\_ Fistulograms & Sinograms

### Ultrasound

\_\_\_\_\_ Small Parts

\_\_\_\_\_ OB/GYN

\_\_\_\_\_ Cardiac

\_\_\_\_\_ Abdomen/Pelvis

\_\_\_\_\_ Intracavitary

\_\_\_\_\_ Doppler

### Mammography

\_\_\_\_\_ Tumor Localization/Biopsy

\_\_\_\_\_ Film/Screen

\_\_\_\_\_ Stereotactic

\_\_\_\_\_ Breast cyst aspirations

### Interventional

\_\_\_\_\_ Vena cava umbrella placement

\_\_\_\_\_ Biliary stone extraction

\_\_\_\_\_ Tube Placement

\_\_\_\_\_ Nephrostomy

\_\_\_\_\_ Needle Aspiration

\_\_\_\_\_ Arthrography

\_\_\_\_\_ Needle Biopsy

\_\_\_\_\_ Myelography

\_\_\_\_\_ Percutaneous Cholangiography

\_\_\_\_\_ Percutaneous abscess or cyst drainage

### MRI

\_\_\_\_\_ Body

\_\_\_\_\_ Spine

\_\_\_\_\_ Joint

\_\_\_\_\_ Head

### Angiography

\_\_\_\_\_ Angioplasty (LTA)

\_\_\_\_\_ Visceral, large vessel

\_\_\_\_\_ Visceral Selective

\_\_\_\_\_ Venography

\_\_\_\_\_ Cranial

\_\_\_\_\_ Lymphangiography

\_\_\_\_\_ Embolization

\_\_\_\_\_ Peripheral

### Nuclear Medicine

\_\_\_\_\_ Cardiac SPECT studies

\_\_\_\_\_ Cardiac Planar studies

\_\_\_\_\_ General SPECT studies

\_\_\_\_\_ General Planar studies

\_\_\_\_\_ Radioactive iodine treatment of hyperthyroidism

\_\_\_\_\_ Radioactive iodine thyroid ablation

\_\_\_\_\_ Radioactive iodine cancer treatment

\_\_\_\_\_ Strontium 89 therapy

### ***Supervision and Interpretation of:***

\_\_\_\_\_ scans of the thyroid gland

\_\_\_\_\_ Whole body iodine scans for thyroid cancer

\_\_\_\_\_ Nuclear cardiology examinations

\_\_\_\_\_ liver/spleen, lung, brain, hepatobiliary

\_\_\_\_\_ system, gastrointestinal system, skeletal

\_\_\_\_\_ systems, and non-cardiac, blood pool imaging

### Other

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**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.

<b>Reference #1:</b>	
Name: _____	Address: _____
Home: (    ) _____	Work: (    ) _____
Pager: (    ) _____	E-mail: _____

<b>Reference #2:</b>	
Name: _____	Address: _____
Home: (    ) _____	Work: (    ) _____
Pager: (    ) _____	E-mail: _____

<b>Reference #3:</b>	
Name: _____	Address: _____
Home: (    ) _____	Work: (    ) _____
Pager: (    ) _____	E-mail: _____

<b>Reference #4:</b>	
Name: _____	Address: _____
Home: (    ) _____	Work: (    ) _____
Pager: (    ) _____	E-mail: _____

<b>Reference #5:</b>	
Name: _____	Address: _____
Home: (    ) _____	Work: (    ) _____
Pager: (    ) _____	E-mail: _____

<b>Reference #6:</b>	
Name: _____	Address: _____
Home: (    ) _____	Work: (    ) _____
Pager: (    ) _____	E-mail: _____



Please complete the following mammography packet in its entirety. The following guidelines and documents must be met and provided:

- If your mammography training was obtained after October 1, 1994, you will need to provide Millenia Medical with a letter from your residency program confirming your mammography training.
- If your mammography training was obtained before October 1, 1994, you will need to complete the enclosed attestation form included in this packet.
- Please provide copies of 15 CME credits completed within the past 36 months.
- You must have read 960 mammography reads within the last 24 months.

Thank you,

Millenia Medical Physician Services



**ATTESTATION REGARDING REQUIREMENTS OF  
THE MAMMOGRAPHY QUALITY STANDARDS ACT**

Attestation must include as much of the following information as possible:

Name of the institution/facility where the applicable training or mammography reading/interpreting, or other activity, took place; name of the course(s) or training (where applicable); the attendance, reading/interpreting, or other activity dates; and the supervising/responsible person (where applicable) for the institution/facility.

Please provide these details in the space below. Attach additional sheets if necessary.

**I, \_\_\_\_\_, attest that, to the best of my knowledge and my belief, the following information provided in this declaration is true and correct. I understand that FDA may request additional information to substantiate the statements made in this declaration:**

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Diagnostic Residency training at: \_\_\_\_\_

From dates: \_\_\_\_\_ to \_\_\_\_\_

During residency – received 40 hours of formal training in mammography and interpreted 240 mammograms during at 6-month period. All of this was prior to October 1, 1994.

**I understand that knowingly providing false information in a matter within the jurisdiction of an agency of the United States could result in criminal liability, punishable by up to \$10,000 fine and imprisonment of up to five years, or civil liability under the MQSA, or both.**

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature and Title

\_\_\_\_\_  
Date signed



## MAMMOGRAPHY READS

Please note the names and addresses of facilities where you have interpreted mammograms for the past two (2) years. You must have 960 reads within the past two (2) years. If you do not have copies, please fill out the contact information below so that Millenia can confirm that you meet the MQSA requirements.

1.	_____	_____
	Facility Name	Address
	_____	_____
	Date	Contact
	_____	_____
	Phone	Number of Reads
2.	_____	_____
	Facility Name	Address
	_____	_____
	Date	Contact
	_____	_____
	Phone	Number of Reads
3.	_____	_____
	Facility Name	Address
	_____	_____
	Date	Contact
	_____	_____
	Phone	Number of Reads
4.	_____	_____
	Facility Name	Address
	_____	_____
	Date	Contact
	_____	_____
	Phone	Number of Reads
5.	_____	_____
	Facility Name	Address
	_____	_____
	Date	Contact
	_____	_____
	Phone	Number of Reads
6.	_____	_____
	Facility Name	Address
	_____	_____
	Date	Contact
	_____	_____
	Phone	Number of Reads
7.	_____	_____
	Facility Name	Address
	_____	_____
	Date	Contact
	_____	_____
	Phone	Number of Reads

8. \_\_\_\_\_  
Facility Name Address  
\_\_\_\_\_  
Date Contact  
\_\_\_\_\_  
Phone Number of Reads

9. \_\_\_\_\_  
Facility Name Address  
\_\_\_\_\_  
Date Contact  
\_\_\_\_\_  
Phone Number of Reads

10. \_\_\_\_\_  
Facility Name Address  
\_\_\_\_\_  
Date Contact  
\_\_\_\_\_  
Phone Number of Reads