



# Prime Staff

Date of Application \_\_\_\_/\_\_\_\_/\_\_\_\_

Applicant Name \_\_\_\_\_

Dear Doctor,

Thank you for your interest in Prime Staff! Please find enclosed an application package for you to complete and mail back to us in the self-addressed envelope provided for you.

Please complete and return the following items:

**CHECK LIST**

- |  |  |
|--|--|
| _____ Curriculum Vitae   | _____ Prime Staff Application          |
| _____ Release of Information Form  | _____ Professional Placement Agreement |
| _____ W-9 Form   | _____ Picture ID (Headshot)            |
| _____ 3 Reference Check Forms (**Please have fellow MDs complete the forms and fax or mail them back to us.**)         |  |
| _____ I-9 Form and copies of acceptable identification (either one item from list A or one item each from lists B & C) |  |

Please provide copies of the following:

- Med License(s) \_\_\_\_\_ DEA \_\_\_\_\_ Controlled Substance \_\_\_\_\_ ACLS/CPR/ATLS/PALS (if Applicable) \_\_\_\_\_
- Medical School Diploma \_\_\_\_\_ ECFMG \_\_\_\_\_ (If Applicable) Board Certification(s) \_\_\_\_\_ (If Applicable)

If you have any questions, please feel free to call me at 713-541-1177 or call toll-free 866-312-1177. Our fax number is 713-953-1925.

Best Regards,

Keri Krueger  
Credentialing Coordinator



# Prime Staff

Application Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date Available: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Physician's Name: \_\_\_\_\_ O MD O DO SS # \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Pager (\_\_\_\_) \_\_\_\_\_  
 Cell Phone (\_\_\_\_) \_\_\_\_\_ E-Mail address: \_\_\_\_\_  
 Driver's Lic. # \_\_\_\_\_ Expires: \_\_\_\_/\_\_\_\_/\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ US Citizen? O Yes O No  
 Place of Birth \_\_\_\_\_ (If no, enclose copy of proof of status)  
 What other languages do you fluently speak? \_\_\_\_\_ Read? \_\_\_\_\_ Write? \_\_\_\_\_

## **EDUCATION:**

Premedical: \_\_\_\_\_  
 (Institution) (Address) (Date)  
 Medical: \_\_\_\_\_  
 (Institution) (Address) (Date)  
 Internship: \_\_\_\_\_  
 (Institution) (Address) (Date)  
 Residency: \_\_\_\_\_  
 (Institution) (Address) (Date)  
 Fellowship: \_\_\_\_\_  
 (Institution) (Address) (Date)

ECFMG (if applicable): Certificate #: \_\_\_\_\_ Issue date: \_\_\_\_\_  
 Specialty: \_\_\_\_\_

Board Certified:  Yes  No Name of certifying board: \_\_\_\_\_

If not board certified, indicate any of the following that apply:

- I have taken the exam, results are pending.
- I have taken Part I and am eligible for Part II to be taken on \_\_\_\_\_ (date).
- I am intending to sit for the Boards on \_\_\_\_\_ (date).
- I am not planning to take the Boards.

## **LICENSURE: List all active and inactive licensure**

Medical License # \_\_\_\_\_ State: \_\_\_\_\_ Issue Date: \_\_\_\_\_ Expires on: \_\_\_\_\_  
 Medical License # \_\_\_\_\_ State: \_\_\_\_\_ Issue Date: \_\_\_\_\_ Expires on: \_\_\_\_\_  
 Medical License # \_\_\_\_\_ State: \_\_\_\_\_ Issue Date: \_\_\_\_\_ Expires on: \_\_\_\_\_  
 Medical License # \_\_\_\_\_ State: \_\_\_\_\_ Issue Date: \_\_\_\_\_ Expires on: \_\_\_\_\_

Controlled Substance License # \_\_\_\_\_ State: \_\_\_\_\_ Issue Date: \_\_\_\_\_ Expires on: \_\_\_\_\_  
 Controlled Substance License # \_\_\_\_\_ State: \_\_\_\_\_ Issue Date: \_\_\_\_\_ Expires on: \_\_\_\_\_  
 Controlled Substance License # \_\_\_\_\_ State: \_\_\_\_\_ Issue Date: \_\_\_\_\_ Expires on: \_\_\_\_\_  
 DEA # \_\_\_\_\_ Expires on: \_\_\_\_\_

UPIN # \_\_\_\_\_

CPR  ATLS  ACLS  BCLS  PALS  NALS   
 (Please include copies)

## **PROFESSIONAL REFERENCES**

10375 Richmond Avenue, Suite 1575, Houston, Texas 77042 (713) 541-1117 / (866) 312-1177 (Toll Free) / (713) 953-1925 (Fax)

Name	Address	Phone	Relationship
Name	Address	Phone	Relationship
Name	Address	Phone	Relationship

**PROFESSIONAL EXPERIENCE** - Chronologically list all positions held within the past five years. Provide explanation of any gaps.

Facility Name	Address	Phone	Fax
Position	Start date	End Date	Reason for leaving
Facility Name	Address	Phone	Fax
Position	Start date	End Date	Reason for leaving
Facility Name	Address	Phone	Fax
Position	Start date	End Date	Reason for leaving
Facility Name	Address	Phone	Fax
Position	Start date	End Date	Reason for leaving

**HOSPITAL AFFILIATIONS**

Do you have Hospital Privileges? Yes \_\_\_\_ No \_\_\_\_

Primary Hospital where you have privileges	Start Date (MM/YYYY)
Address	
City	State Zip
Phone Number	Fax Number
Other Hospital where you have privileges	Start Date (MM/YYYY)
Address	
City	State Zip
Phone Number	Fax Number
Other Hospital where you have privileges	Start Date (MM/YYYY)
Address	
City	State Zip
Phone Number	Fax Number

Other Hospital where you have privileges

Start Date (MM/YYYY)

Address

City State Zip

Phone Number Fax Number

Other Hospital where you have privileges

Start Date (MM/YYYY)

Address

City State Zip

Phone Number Fax Number

Previous Hospital where you had privileges

Application Date From - To

Address

City State Zip

Phone Number Fax Number

Previous Hospital where you had privileges

Application Date From - To

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City State Zip

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Application Date From - To

Address

City State Zip

Phone Number Fax Number

**Disclosure Questions:** Please provide an explanation for any questions answered “YES” (except questions 12 and 18).

**Licensure and Controlled Substances Certificates**

- 1. Has your license or certification to practice in your profession ever been denied, suspended, revoked, restricted, voluntarily or involuntarily surrendered, or have you ever been subject to a consent order, probation, or any conditions or limitations by any state licensing board? Yes  No
- 2. Have you ever been reprimanded or fined by any state licensing or certification board? Yes  No
- 3. Have any of your Federal DEA or DPS Controlled Substance Certified or prescriptive authorities ever been denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?  
No Yes  No
- 4. Are there currently any pending challenges to any of your state licenses, DEA, prescriptive authority or state controlled substance registrations? Yes  No

**Hospital Privileges and Other Affiliations**

- 5. Have your clinical privileges or professional staff membership at any hospital or health care institution ever been involuntarily terminated, surrendered, limited, reduced, denied, suspended, revoked, restricted, denied renewal, or subjected to probationary or to other disciplinary conditions (for reasons other than automatic action based on non-completion of medical records), or have proceedings toward any of those ends been instituted or recommended by any hospital or health care institution, medical staff or committee or governing board? Yes  No
- 6. Have you voluntarily surrendered or withdrawn an application, limited your privileges, or not reapplied for privileges? Yes  No
- 7. Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)? Yes  No

**Education, Training and Board Certification**

- 8. Are you currently or have you ever been placed on probation, under restriction or limitation, disciplined, reprimanded, suspended, terminated, or asked to resign during and internship, residency, fellowship, preceptorship, or other clinical education program? Yes  No
- 9. Have you ever voluntarily resigned or terminated prematurely your status as a student or employee in an internship, residency, fellowship, preceptorship or other clinical education program while under investigation or in return for not conducting an investigation? Yes  No
- 10. Have any of your board certifications or eligibility for board certification ever been revoked? Yes  No
- 11. Have you ever chosen not to recertify or voluntarily surrendered any of your board certifications while under investigation or in return for not conducting an investigation? Yes  No
- 12. Are you authorized by the Texas State Board of Nurse Examiners in the same Advanced Practice Nurse roles and/or specialties for which you seek credentialing (APN only)? Yes  No

**Medicare, Medicaid or other Governmental Program Participation**

- 13. Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid Program, or in regard to other federal or state governmental health care plans or programs? Yes  No

**Other Sanctions or Investigations**

- 14. Are you currently or have you ever been the subject of an investigation by any hospital or health care institution, licensing authority, DEA or DPS authorizing entity, education or training program, Medicare or Medicaid program, or any other private, state or federal health program? Yes  No
- 15. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank? Yes  No

16. Have you ever been sanctioned or declared an ineligible person by any federal or state regulatory agency (e.g., Office of Inspector General (OIG), Health & Human Services Commission (HHSC), Clinical Laboratory Improvement Amendments (CLIA), Occupational Safety & Health Administration (OSHA), etc.)? Yes  No
17. Are you currently or have you ever been investigated, sanctioned, reprimanded or cautioned by a government (e.g., Department of Defense, Veterans Administration) hospital or facility, or been terminated or asked to resign while under investigation by a government hospital or facility? Yes  No

**Malpractice Claims History**

18. Have any arbitrated, litigated, mediated, pending, dismissed or settled before filing professional malpractice actions, claims or notices of claim ever been filed or submitted against you? Yes  No
- If yes, please check this box and explain on attached sheet*
19. Has your professional liability insurance policy ever been cancelled or renewal refused? Yes  No
20. Have limitations ever been placed on the scope of coverage or have you received notice of intent? Yes  No

**Criminal**

21. Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony? Yes  No
22. Was this felony reasonably related to your qualifications, competence, functions, or duties as a health care professional? Yes  No NA
23. Did this felony involve a violent or sexual offense against a child, or an elderly or disabled person? Yes  No NA
24. Have you ever been court-martialed for actions related to your duties as a health care professional? (Please check N/A if you have not served in the military) Yes  No NA

**Health Status and Ability to Perform Job**

25. Are you currently or have you ever been diagnosed with or received treatment for any physical, mental, chemical dependency or emotional condition which could in any way impair your ability to care for patients or perform the essential functions of your health profession in your specialty? Yes  No
26. Are you currently limited by any physical, mental or chemical dependency problem which could in any way impair your ability to care for patients or perform the essential functions of your health profession in your specialty now or within the next three years? Yes  No

**Health Status and Ability to Perform Job**

27. Are you currently engaged in the illegal use of drugs? (“Currently” means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one’s ability to practice their health care profession. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. “Illegal use of drugs” refers to drugs whose possession or distribution is unlawful under the controlled Substances Act, 21 U.S.C. § 812.22. It does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substance Act or other provision of Federal law.” The term does not include, however, the unlawful use of prescription controlled substances.) Yes  No
28. Do you use any chemical substance that would in any way impair your ability to care for patients or perform the essential functions of your health profession in your specialty with reasonable skill and safety? Yes  No
29. Are you currently or have you ever been placed under a monitoring or rehabilitation contract or agreement by any professional society or institution for problems associated with a chemical dependency or emotional condition, or for unprofessional or disruptive behavior? Yes  No
30. Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients? Yes  No
31. Are you unable to perform the essential functions of a practitioner in your area of practice with or without reasonable accommodation? Yes  No



**10375 Richmond Avenue, Suite 1575, Houston, Texas 77042 (713) 541-1117 / (866) 312-1177 (Toll Free) / (713) 953-1925 (Fax)**

Prime Staff MD/DO Non TX Application 1/22/2008



## **PROFESSIONAL PLACEMENT AGREEMENT**

This Agreement is made by and between **PRIME STAFF** hereinafter referred to as "**Prime Staff**" or "Company" and \_\_\_\_\_ hereinafter referred to as "Contractor," and is effective as of the date of execution by the parties. The purpose of this Agreement is to set forth the terms and conditions under which **Prime Staff** will attempt to secure temporary and/or full-time contractual work for the Contractor.

In consideration of the mutual covenants and agreements contained in this Agreement, the parties agree as follows:

1. **Contractor Not an Employee.** The parties intend to establish an independent contractual relationship rather than an employer/employee relationship. Contractor agrees that he/she is not an employee, agent or legal representative of **Prime Staff** for any purpose. Contractor is not granted any express or implied right or authority to assume or to create any obligation or responsibility on behalf of the name or in the name of **Prime Staff** or to bind **Prime Staff** in any manner.

2. **Contractor Duties and Control.** Contractor will maintain and keep current all appropriate and applicable professional licenses and certifications. Contractor shall not be obligated to accept any contractual work that **Prime Staff** may suggest or to which **Prime Staff** may refer the Contractor, and Contractor understands that **Prime Staff** does not guarantee or represent that Contractor will be offered employment or contractual work by any medical service provider to which **Prime Staff** may refer or recommend the Contractor. **Prime Staff** will use its best effort to find a position for Contractor in accord with the desires of the Contractor as to position and hours, either for either temporary or full-time contractual work, with a provider of medical services. Contractor understands and agrees that Contractor retains the sole and exclusive right to control the manner or means by which his services under this Agreement to any medical service provider are to be performed.

3. **Termination.** This Agreement may be terminated with or without cause or reason by either **Prime Staff** or Contractor upon fourteen (14) calendar day's written notice to the other party. Notice shall be sent or delivered to Contractor at 10375 Richmond Avenue, Suite 1575, Houston, Texas 77042 at **Prime Staff's** offices, by certified mail. However, the parties agree that their rights and obligations under provisions 4, 5, 6, 7, 9, 12, 13, 14, 17, and 18 of this Agreement shall continue.

4. **Contractor's Work.** Contractor understands that he/she cannot accept a position for his/her services at a medical facility client of **Prime Staff** or an affiliate of such Client for two (2) years after termination date with **Prime Staff**. Contractor understands that if he/she accepts placement for his/her services at a medical facility Client of **Prime Staff**, or an affiliate of such Client, within two (2) years after Contractor's placement or **Prime Staff's** introduction of Contractor to Client or **Prime Staff's** provision of Contractor's curriculum vitae to Client, that **Prime Staff** will be entitled to receive the scheduled Finder's Fee from **Prime Staff's** Medical Facility or affiliate or Contractor. Within such two-year period, Contractor will not accept employment or agree to provide services unless the Finder's Fee is paid to **Prime Staff**. The parties agree that the termination of this Agreement shall have no effect on the rights and obligations of the parties under this provision.

5. **Reimbursement.** Contractor agrees to be available to provide Locum Tenens services for the Medical Facility Clients of **Prime Staff** as agreed upon by the parties. Contractor assigns to **Prime Staff** the right to receive contract payments for Locum Tenens services from **Prime Staff's** Medical Facility Clients and their affiliates made pursuant to this agreement. Contractor will be paid by **Prime Staff** weekly. If, however, Contractor is interested only in pursuing full time employment with **Prime Staff's** client(s), **Prime Staff** can provide referral/placement services to include fees for full-time employment or contractual work. Applicable fees are negotiated to fit terms and circumstances of placement.

6. **Payment of Taxes and Other Payments.** Contractor will not be treated as an employee for federal or state tax purposes with respect to the services rendered under this Agreement. Contractor shall be responsible for payment of all taxes arising out of the Contractor's activities under this agreement, including by way of illustration but not limitation, federal and state income tax, Social Security tax, unemployment insurance taxes, and any other taxes or business license fees as required. **Prime Staff** will, to the extent it is legally required to do so, file all necessary tax information and reports with federal, state and local taxing authorities, including an Internal Revenue Service Form 1099, to report the income of Contractor arising under this Agreement. **Prime Staff** will not withhold or pay any taxes, including but not limited to, FICA, FUTA, federal personal income taxes, state personal income taxes, state disability insurance taxes, and state unemployment insurance, if any; and any other form of social security, unemployment taxes and/or workers' compensation, or any other assessments or taxes from the payments that **Prime Staff** makes to Contractor, unless it is required to do so by law notwithstanding the independent contractual relationship of the parties. In the event that **Prime Staff** is required to make payments to the Internal Revenue Service for Contractor's share of FICA or withholdings for past payment periods, Contractor agrees that **Prime Staff** is entitled to withhold such amounts from future payments to Contractor, under this Agreement. Contractor represents and warrants that he will report all income earned from **Prime Staff** pursuant to this Agreement, and will pay all federal, state and local income and self-employment taxes and other assessments required to be paid by him under the law.

7. **Benefits.** The Services performed by Contractor shall be as an independent contractor and not as an employee. Accordingly, Contractor is not entitled to the benefits provided by **Prime Staff** to its employees including, but not limited to, group insurance and participation in **Prime Staff's** employee benefit, workers compensation and pension plans.

(a) In no event shall Contractor (and his/her employees, if any) become eligible to participate in a **Prime Staff** -sponsored benefit program; Contractor hereby waives any such right to participate in the program. This waiver of any right to participate in **Prime Staff** -sponsored employee benefit programs represents a material component of the terms of payment agreed to by the parties. This paragraph waives eligibility for all Company-sponsored benefit programs.

(b) Contractor acknowledges that Contractor is not covered by **Prime Staff's** health insurance plan. Moreover, as an independent contractor, Contractor will be responsible for all insurance coverage, with the sole exception of Contractor's professional liability insurance. **Prime Staff** reserves the right to request proof of applicable insurance coverage from Contractor at anytime. Accordingly, **Prime Staff** will have no responsibility with regard to Contractor's health insurance, automobile insurance, and workers' compensation insurance, but **Prime Staff** agrees to provide medical malpractice insurance coverage under **Prime Staff's** current group malpractice policy for the Contractor's actions or omissions in the normal course of Placement while working for **Prime Staff** clients only made under this contract, provided information submitted by Contractor pursuant to his/her application is true and complete. Professional malpractice insurance covers each individual assigned by **PRIME STAFF** to **CLIENT** and shall be the sole responsibility of **PRIME STAFF** and **PRIME STAFF** shall provide proof of coverage, prior to assignment, (1) that each individual assigned has limits for professional liability up to \$1,000,000 per occurrence and \$3,000,000 annual aggregate but not to exceed the monetary terms and limits contained in the facility **Client's** agreement with **Prime Staff**. Contractor agrees to provide full cooperation in the defense of any malpractice suit, if any. **Prime Staff's** obligation to provide medical malpractice insurance to contractor shall end upon termination of this Agreement by any party for any reason.

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8. Notice. Contractor agrees hereby as an absolute condition of continued work to advise **Prime Staff** as soon as possible prior to any scheduled workday for which Contractor will not be available or not be able to perform services. Contractor understands that the positions to which Contractor may be referred are of vital importance, involving medical services, and that the Contractor providing coverage at the correct time and place is of vital concern.

9. Disclaimer of Liability and Release, and Indemnification. Contractor shall release, defend, protect, indemnify, and save **Prime Staff** harmless from and against all liability, claims, costs, expenses, damages (whether actual, consequential, special or punitive) demands, suits, and causes of action of every kind and character (the "claims") arising in favor of any person, corporation, or other entity, including Contractor and their contractors or agents, on account of malpractice, personal injuries or death, or damages to property in anywise incident to or in connection with or arising out of (a) the services performed pursuant to this Agreement; (b) this Agreement; (c) the presence of Contractor on **Prime Staff**'s premises or the premises of any medical facility client; or (d) the act or omission of Contractor or Contractor's contractors or agents. Although Contractor may be a subscriber under a worker's compensation act, disability act, or other employee benefit act that would limit the amount of type of damages, compensation, or benefits payable by or for Contractor, Contractor expressly assumes the entire liability pursuant to this provision for any and all claims against **Prime Staff** arising in favor of Contractor or his/her representatives and beneficiaries.

10. Disclosure Authorization. Contractor hereby authorizes **Prime Staff** to contact prior employers, to obtain State license records, and to inquire of all references, of which not less than three physician references shall be provided by Contractor to **Prime Staff**. Contractor will provide **Prime Staff** with copies of current license from the appropriate state's Medical Examiners State Licensing Board, Department of Public Safety, and Drug Enforcement Agency.

11. Compliance with Laws. Contractor agrees to comply with all federal state and local laws, rules and regulations pertaining to their performance under this Agreement.

12. Confidential Information. The Contractor agrees that he will not disclose or cause to be disclosed or use for his personal gain or benefit any confidential or proprietary information, records, or documents relating to the practice, services, operations or business of **Prime Staff** or **Prime Staff** Clients, which the Contractor gained during the term of this Agreement, or while providing the services under this Agreement. All patient information will be utilized and disclosed by the Contractor only in accordance with all applicable laws and regulations, including, but not limited to, regulations relating to privacy and security published by the United States Department of Health and Human Services according to the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

13. Entire Agreement. This Agreement constitutes the entire agreement between **Prime Staff** and Contractor with respect to the subject matter contained in this Agreement and supersedes all prior agreements and understandings, whether written or oral, between them concerning such terms of employment.

14. Severability. In the event that any provision or provisions of this Agreement is held to be invalid or unenforceable by any court of law or otherwise, the remaining provisions of this Agreement shall nevertheless continue to be valid and enforceable as though the invalid or unenforceable parts had not been included therein.

15. Nonexclusive Agreement. This Agreement is non-exclusive to both parties and either party may engage in business relationships with other entities regarding the services which are the subject of this Agreement.

16. Amendments. No changes or alterations to this agreement shall be binding upon either party unless in writing and signed by both parties.

17. Governing Law. This Agreement shall be governed by the laws of Harris County of the state of Texas, and the parties consent to venue and personal jurisdiction over them in Texas state courts and in Federal District Court for the Southern District of Texas, as applicable, for purposes of construction and enforcement of this Agreement.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Independent Contractor

\_\_\_\_\_  
Prime Staff

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**STATEMENT OF HEALTH**

- 1. Do you have any physical or psychiatric condition which would interfere with your ability to practice your specialty competently?  Yes  No
- 2. Have you been under the care of a physician, treated for any mental/physical condition, or hospitalized in the past two (2) years?  Yes  No
- 3. Do you have a physical condition which would affect you exercising the privileges you have requested?  Yes  No
- 4. Have you ever been treated for substance abuse, or do you have a history of alcohol or substance abuse?  Yes  No

If yes to any of the above, please explain.

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

DATE OF APPLICATION: \_\_\_\_\_

DATE AVAILABLE: \_\_\_\_\_



## Release of Information

By applying for consideration as a contractor with **Prime Staff**, I hereby make the following authorizations:

### References:

Authorize **Prime Staff** and its representatives to consult with my current and prior associates and others who may have information bearing on my professional competence, character, health status, ability to work cooperatively with others, ethical qualifications, clinical competence and other qualifications for membership and clinical privileges and to verify information set forth in my application.

### Inspection of Records:

Consent to the inspection by **Prime Staff** and its representatives of all records and documents, including medical records hospitals, which may be material to an evaluation of my professional qualifications and competence, as well as my moral qualifications.

### Insurance:

Authorize the release of information from all current and prior insurance carrier(s) regarding any claims history with professional liability insurance carrier(s).

### Release from Liability:

Release from liability and all individuals and organizations that provide information to **Prime Staff** in good faith and without malice concerning my professional competence, ethics, character and other qualification.

### Right to Review:

Authorize the physicians' right to review the information in support of their credentialing application, the right upon request to be informed of the status of the credentialing application and the right to be informed during the credentialing process of information that differs from information that was reported by the applicant and have the right to correct erroneous information.

\_\_\_\_\_  
Signature

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

\_\_\_\_\_  
Date



# REFERENCE

Applicant: \_\_\_\_\_,

Areas of Evaluation	Excellent	Good	Average	Poor	No Knowledge
Basic Medical Knowledge					
Overall Clinical Performance					
Management of Major Trauma / Acute Medical Illness					
EKG Interpretations					
Histories & Physicals					
Motivation/Ambition					
General Behavior					
Rapport w/Medical Staff					
Rapport w/ Nursing Staff					
Patient Relationships					
Appearance					
Emotional Stability					

What is the nature and duration of your association with applicant?

Do you have any knowledge of alcohol or drug problems relating to this candidate?

**If you feel that you cannot evaluate this candidate on any of the above issues, please explain below:**

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_  
(Please print clearly)

Address: \_\_\_\_\_  
(City) (State) (Zip)

Contact Phone #: \_\_\_\_\_

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

Are you interested in hearing from Prime Staff regarding permanent placement or locum tenens assignments?  Yes  No  
Are you interested in hearing from Prime Staff regarding using locum tenens physicians/allied health professionals in your facility?  Yes  No

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# REFERENCE

Applicant: \_\_\_\_\_,

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Rapport w/ Nursing Staff					
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Appearance					
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What is the nature and duration of your association with applicant?  
\_\_\_\_\_

Do you have any knowledge of alcohol or drug problems relating to this candidate?  
\_\_\_\_\_  
\_\_\_\_\_

**If you feel that you cannot evaluate this candidate on any of the above issues, please explain below:**

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_  
(Please print clearly)

Address: \_\_\_\_\_  
(City) (State) (Zip)

Contact Phone #: \_\_\_\_\_

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

Are you interested in hearing from Prime Staff regarding permanent placement or locum tenens assignments?  Yes  No  
Are you interested in hearing from Prime Staff regarding using locum tenens physicians/allied health professionals in your facility?  Yes  No



# REFERENCE

Applicant: \_\_\_\_\_,

Areas of Evaluation	Excellent	Good	Average	Poor	No Knowledge
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Overall Clinical Performance					
Management of Major Trauma / Acute Medical Illness					
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Rapport w/Medical Staff					
Rapport w/ Nursing Staff					
Patient Relationships					
Appearance					
Emotional Stability					

What is the nature and duration of your association with applicant?  
\_\_\_\_\_

Do you have any knowledge of alcohol or drug problems relating to this candidate?  
\_\_\_\_\_  
\_\_\_\_\_

**If you feel that you cannot evaluate this candidate on any of the above issues, please explain below:**

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_  
(Please print clearly)

Address: \_\_\_\_\_  
(City) (State) (Zip)

Contact Phone #: \_\_\_\_\_

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

Are you interested in hearing from Prime Staff regarding permanent placement or locum tenens assignments?  Yes  No  
Are you interested in hearing from Prime Staff regarding using locum tenens physicians/allied health professionals in your facility?  Yes  No

**DIRECT DEPOSIT INFORMATION**

10375 Richmond Avenue, Suite 1575, Houston, Texas 77042 (713) 541-1117 / (866) 312-1177 (Toll Free) / (713) 953-1925 (Fax)

Dear Prime Staff Physician,

Prime Staff is pleased to be able to offer you the convenience of Direct Deposit. Please complete the enclosed form and attach a VOIDED check from the account to which you want your check deposited. There are a few details you should understand before starting this service.

Direct Deposits will be sent out only once per week and will be deposited on Fridays to your account. This requires that your signed and completed *timesheets must be faxed to the Prime Staff office by 2pm on Monday* for shifts worked the previous week. It is your responsibility to fax the time sheets each Monday and to confirm that they were received in our office. Due to the volume of paychecks we process weekly, it is impossible for the office staff here at Prime Staff to track down timesheets for you. If you fail to provide a signed timesheet by Monday at 2pm, you will not receive a direct deposit check on Friday.

**DIRECT DEPOSIT GUIDELINES**

Approved timesheets and substantiated reimbursable expenses must be received in our office by 2:00 pm Monday. Employee/Independent Contractor should expect deposit on Friday. Any banking holidays may delay direct deposit date.

Prime Staff is not responsible for inaccurate information supplied by employee, errors made by financial institutions, or any fees imposed by employee's financial institution.

A remittance advice will be mailed to the home address on record.

Once employee/independent contractor has signed up for direct deposit, a manual paycheck cannot be issued without employee/contractor's written authorization received in such a manner as to afford Prime Staff a reasonable opportunity to act on it. Written authorization will also be needed to resume direct deposit.

Any discrepancies or errors in payroll should be reported to our office as soon as possible for correction. Please review your direct deposit remittance advice carefully.

Original timesheets supporting the direct deposit must be delivered to Prime Staff no less often than weekly. Failure to submit original timesheets will result in the employee becoming ineligible for future direct deposits.

David S. Garner, Controller  
Prime Staff

**AUTHORIZATION FOR DIRECT DEPOSIT**

I hereby authorize **Prime Staff**, hereinafter called COMPANY, to initiate credit entries and to initiate, if necessary, adjustments for any debit or credit entries in error to my checking account indicated below and the depository named below, hereinafter called DEPOSITORY, to credit and/or debit the same to such account. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.

BANK NAME \_\_\_\_\_

ROUTING # \_\_\_\_\_ ACCOUNT # \_\_\_\_\_

(Routing/Transit number may be printed on a different location than at the bottom of the check. Please verify with your bank the correct number to use for payroll direct deposit.)

The authority is to remain in full force and effect until COMPANY has received written notification from me of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

NAME \_\_\_\_\_ SS# \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**\*\* Please attach a voided check for your checking account \*\***

Remember, the routing and account numbers on this form should match the attached voided check. Please be advised that we will submit the routing number you enter on this form, not the one on your voided check, in the event the numbers are different. A \$1.00 "pre-note" will be initially wired to your account. You should call your bank to confirm receipt. If we do not hear from you within a week's time, we will presume the \$1.00 pre-note was successful and will deposit your next paycheck as a direct deposit. We will deduct back the \$1.00 from a later paycheck.

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FOR COMPANY USE ONLY

Date rec'd in acctg \_\_\_\_\_ processed by \_\_\_\_\_ prenote sent \_\_\_\_\_

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