Whitesell
Medical Staffing, LTD.

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Request For Service

Your assistance in filling out this Request for Services form will greatly aid us in our search for a physician to meet your specific needs. Your time is appreciated.

Date: _____

Organization Making Request: _____

Address: _____
_____

Phone: _____ Fax: _____

Coverage Specifics:

1. Specialty of Physician: _____
2. Dates Physician Needed: _____
3. Reason For Need: _____
4. Clinic/Hospital name if different from Organization making request: _____
   Address: _____
   _____
   Phone and Fax: _____
5. Contact Person: _____
6. Community size/description: _____
7. Nearest Airport: _____
8. Lodging Arrangements: _____
9. Transportation: _____
10. Physician Attire: _____

Clinic Data:

1. Office days and hours: _____
2. Number of physicians: _____
3. Patient ratio: Pediatric ____% Geriatric ____% Adolescent ____% Adult ____%
   Workman's Compensation ____% Medicare ____% Medicaid ____%
4. Office staff: _____
5. Office space: # of exam rooms: ____ X-ray: ____ Lab runs: ____
6. Required procedures: _____
7. Daily Number of outpatients: _____
8. Emergency room responsibilities: _____
9. Emergency Supplies: Crash Cart □ Inhaler □ Defibrillator □ Oxygen □ Other □
10. Please list preferred certification requirements (e.g., board certified, board eligible, ACLS, ATLS, etc.):
    _____
11. Distance to hospital facilities: _____
12. Other facilities: □ Long- term facility □ Mental health facility
    □ Paramedics (describe level of service – IV, administer drugs, intubation): _____
    _____

Hospital Data:

Name of Hospital: _____
Address: _____

1. Contact person: _____
2. Phone: _____ Fax _____
3. Number of beds: _____
4. List any special hospital privileges required: _____
   (Please allow time to process and grant hospital privileges, if needed.)
5. Type of physician services required, i.e., primary, back-up, admits, rounds: _____
   _____
6. Scheduled hours and information:

	AM	TO	PM
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

ER TRAUMA LEVEL	I II III N/A
NURSERY LEVEL	I II III N/A
RADIOLOGY	CT MRI 24HR
LAB	TECH 24HR
STAT LAB	YES NO
# OF BEDS IN ICU	
INTERMEDIATE CARE UNIT	YES NO
CONSULT BACKUP FOR FAX	YES NO
LABOR AND DELIVERY UNIT	YES NO
PEDIATRIC UNIT	YES NO
REHABILITATION UNIT	YES NO
EKG,FSE? OTHER:	

7. Average daily visits: _____ % Scheduled: _____ % Walk-ins: _____
8. Type of Patients:
   % Minor medical _____ % Prenatal _____ % Adult medical _____ %Minor Trauma _____
   % Gynecological _____ % Workers Compensation physicals _____ % Newborn _____
   % OB _____
9. Protocol for after-hour admissions in the hospital:
10. Nearest specialty services with comment: _____
    Cardiology: _____ OB/GYN: _____ Pulmonary: _____ High-risk pediatrics: _____ GI: _____
    Orthopedics: _____ Otolaryngology: _____ General surgery: _____

Orientation of Locum Tenens Physician:

Do you require an orientation for the physician so that he/she will have a thorough understanding of the policies and procedures? ____

Other Comments: _____
_____
_____

Request for Services Form Completed By: _____
Title: _____
Date: _____

THANK YOU FOR YOU REQUEST
WHITESELL MEDICAL LOCUMS, LTD.