PO BOX 997
Annandale, MN 55302

C - 612-270-8094

Request For Service

Whitesell
Medical Staffing, LTD.

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: _____

How did you hear about us? _____

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/UC Data:

1. Office days and hours: _____
2. Number of physicians: _____
3. Patient ratio: Pediatric ____% Geriatric ____% Adolescent ____% Adult ____%
   Workman's Compensation ____% Medicare ____% Medicaid ____%
4. Type of dictation/EMR: _____
5. Is there training required for EMR: _____Yes _____ No If yes, how much time_____
6. Office space: # of exam rooms: ____ X-ray: ____ Lab runs: ____
7. Required procedures: _____
8. Daily Number of outpatients: _____
9. Emergency room responsibilities: _____
10. Emergency Supplies: Crash Cart Inhaler Defibrillator Oxygen Other
11. Please list preferred certification requirements (e.g., board certified, board eligible, ACLS, ATLS, etc.):
    _____
12. Distance to hospital facilities: _____
13. Other facilities: Long- term facility Mental health facility
    Paramedics (describe level of service – IV, administer drugs, intubation): _____

_____

Emergency Department Information:

Name of Hospital: _____
Address: _____

1. Contact person: _____
2. Phone: _____ Fax _____
3. Number licensed beds: _____
4. Critical Access Hospital ____Yes ___ No Trauma Level I__ II__ III __ IV__
5. Certification requirements(CALS, ATLS etc.)_____
6. BC____ BE____
7. ED doctor on call ___ On Site ___ Off Site
8. T system_____ EMR_____ Other_____
9. What shift coverage is needed(i.e. 8a – 8p,8p-8a, etc): _____
10. What is the maximum length of a shift:_____
11. List any special hospital privileges required: _____
12. Is the doctor required to round on patients ___ Yes ___ No
13. Is there back-up available ___ Yes ___NO If yes, explain_____
    _____
14. **What is the volume of this ED** _____
15. What transfer sites are available _____
16. Does ED operate as a UC for any time frame ___Yes ___ No If Yes, what are the hours_____
    _____
17. Average daily visits: _____ % Scheduled: _____ % Walk-ins: _____
18. Type of Patients: % Minor medical _____ % Prenatal _____ % Adult medical _____
    %Minor Trauma _____ . % Gynecological _____ % Workers Compensation physicals _____
    % Newborn _____ % OB _____

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 STAFFING, LTD.