



## Request For Service

1630 Anderson Avenue  
Suite 100  
Buffalo, MN 55313

763-682-5906  
1-800-876-7171  
FAX: 763-684-0243

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.**