MedicalDoctor ASSOCIATES

Initial Dental Application

FOR INTERNAL USE ONLY: ERECRUIT ID: _____

ASSIGN. START DATE: _____

RECRUITER: _____

SPECIALTY: _____

We are excited to welcome you to working locum tenens with Medical Doctor Associates (MDA), Your Proven Quality Partner in Medical Staffing.

The following packet is your application. In order to ensure timely processing, please note the following requests:

The application must be completed, signed, and dated. No section should be left blank. If the section/question does not apply, simply indicate this with N/A (Not applicable).

In addition to your application, we request the following photocopies of documents be sent to MDA. Including as many of these as possible upfront will make your application processing as timely as possible. There are two sections in our checklist. Those items that we know our insurance carrier wants to see, and those items that are often required by our clients upon acceptance when working specifically in a hospital setting. While all of the items are not required, the more thorough you can be on the front end will better ensure that our consultants can maximize your acceptance to assignments of your preference.

- ❑ **Current Curriculum Vitae** (The CV must include your work history, from completion of training to the present. All dates older than 5 years must include month and year, and not contain any gaps in time.)
- ❑ **All Training Diplomas**
- ❑ **Board Certification (Certificate or Letter)**
- ❑ **Active and Inactive Medical Licenses (Wallet Copy)**
- ❑ **Federal DEA/State Controlled Dangerous Substances Permits**
- ❑ **Past and Current Certificate of Insurance**
- ❑ **Current Photo**
- ❑ **Small Business Administration Attestation Form** (included in packet)
- ❑ **MDA Direct Deposit Form** (included in packet)
- ❑ **IRS Form W-9 (included in packet)**

In addition, the below items are typically requested from our clients upon acceptance of assignment. Having these items upfront however CAN and WILL only help MDA to be as efficient as possible with our client partners for both presentations and client application upon acceptance.

- ❑ **CAQH ID Number (If Applicable)**
- ❑ **Current PPD results within last 12 months or equivalent Chest X-ray, Quantiferon Gold results**
- ❑ **Immunizations (MMR specifically)**
- ❑ **Current Flu shot**
- ❑ **CMEs** within last 2 years

Upon submission of your application, our RISK MANAGEMENT Department will process your application as quicky as possible. Should you have any questions about your application, or about locums assignments, please don't hesitate to ask your Staffing Consultant.

Thank you for allowing us the opportunity to work with you!

Name: _____

GENERAL INFORMATION

LAST NAME		FIRST NAME		MIDDLE NAME	
DEGREE	GENDER ❑ MALE ❑ FEMALE	DATE OF BIRTH	SSN	DRIVERS LICENSE STATE/NUMBER	
SPECIALTY		OTHER NAMES USED		MAIDEN	
HOME ADDRESS			CITY	STATE	ZIP
HOME PHONE		CELL PHONE		EMAIL	
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)			CITY	STATE	ZIP

US CITIZEN ❑ YES ❑ NO

IF NOT A US CITIZEN, ARE YOU AUTHORIZED TO WORK IN THE US? ❑ YES ❑ NO IF NOT A U.S. CITIZEN PLEASE PROVIDE VISA STATUS

BIRTH PLACE (CITY, STATE, COUNTRY)	LANGUAGES SPOKEN		
EMERGENCY CONTACT	RELATIONSHIP	PHONE	CELL PHONE

MILITARY SERVICE

BRANCH OF SERVICE	DATES OF SERVICE: FROM / / TO / /	
RANK AT DISCHARGE	TYPE OF DISCHARGE	SERVICE #

LICENSES AND IDENTIFICATION NUMBERS

STATE	LICENSE#	STATUS: (ACTIVE OR INACTIVE)	CONTROLLED SUBSTANCE #, IF APPLICABLE	STATE	LICENSE #	STATUS: (ACTIVE OR INACTIVE)	CONTROLLED SUBSTANCE #, IF APPLICABLE

DEA #	EXP DATE / /	NATIONAL PROVIDER ID (NPI)

Name: _____

BOARD CERTIFICATIONS

IF NOT CURRENTLY BOARD CERTIFIED, PLEASE CHECK HERE:_____

CERTIFYING BOARD	SPECIALTY	DATE CERTIFIED / /	RECERTIFICATION DATE / /	CERTIFICATION #
EXPIRATION DATE / /	LIFETIME ❑	ELIGIBLE/EXAM DATE / /	DO YOU PLAN TO SIT FOR YOUR BOARDS? IF SO, WHEN?	# OF ATTEMPTS
CERTIFYING BOARD	SPECIALTY	DATE CERTIFIED / /	RECERTIFICATION DATE / /	CERTIFICATION #
EXPIRATION DATE / /	LIFETIME ❑	ELIGIBLE/EXAM DATE / /	DO YOU PLAN TO SIT FOR YOUR BOARDS? IF SO, WHEN?	# OF ATTEMPTS

DENTAL EDUCATION

DENTAL EDUCATION/INSTITUTION				DEGREE ATTAINED
ADDRESS				PROGRAM COMPLETED? ❑ YES ❑ NO
CITY	STATE	ZIP	FROM / /	TO / /

POST GRADUATE EDUCATION

1. INTERNSHIP ❑ RESIDENCY ❑ FELLOWSHIP ❑ OTHER:_____

INSTITUTION/FACILITY NAME			CHAIRMAN		TYPE OF PROGRAM/SPECIALTY
ADDRESS					PROGRAM COMPLETED? ❑ YES ❑ NO (explanation)
CITY	STATE	ZIP	FROM / /	TO / /	IN GOOD STANDING WITH THE PROGRAM? ❑ YES ❑ NO (explanation)

2. INTERNSHIP ❑ RESIDENCY ❑ FELLOWSHIP ❑ OTHER:_____

INSTITUTION/FACILITY NAME			CHAIRMAN		TYPE OF PROGRAM/SPECIALTY
ADDRESS					PROGRAM COMPLETED? ❑ YES ❑ NO (explanation)
CITY	STATE	ZIP	FROM / /	TO / /	IN GOOD STANDING WITH THE PROGRAM? ❑ YES ❑ NO (explanation)

PROFESSIONAL REFERENCES

PLEASE LIST FOUR (4) PEERS WHO HAVE WORKED WITH YOU **IN THE PAST TWO (2) YEARS** AND CAN ATTEST TO YOUR COMPETENCE. IF POSSIBLE THESE REFERENCES SHOULD BE **WITHIN YOUR SPECIALTY.**

NAME	SPECIALTY	INSTITUTION
PHONE/CELL	FAX	EMAIL
NAME	SPECIALTY	INSTITUTION
PHONE/CELL	FAX	EMAIL
NAME	SPECIALTY	INSTITUTION
PHONE/CELL	FAX	EMAIL
NAME	SPECIALTY	INSTITUTION
PHONE/CELL	FAX	EMAIL

Name: _____

WORK HISTORY WITHIN THE PAST 5 YEARS

HOSPITAL/FACILITY	STAFF/STATUS	FROM / /	TO / /	PRESENT ❑
ADDRESS	CITY	STATE	ZIP	
HOSPITAL/FACILITY	STAFF/STATUS	FROM / /	TO / /	PRESENT ❑
ADDRESS	CITY	STATE	ZIP	
HOSPITAL/FACILITY	STAFF/STATUS	FROM / /	TO / /	PRESENT ❑
ADDRESS	CITY	STATE	ZIP	
HOSPITAL/FACILITY	STAFF/STATUS	FROM / /	TO / /	PRESENT ❑
ADDRESS	CITY	STATE	ZIP	

PREVIOUS LOCUM TENENS EXPERIENCE

PLEASE LIST ALL LOCATIONS WHERE YOU HAVE PROVIDED LOCUM TENENS COVERAGE BEGINNING WITH THE MOST RECENT. PLEASE LIST ON AN ADDITIONAL SHEET, IF NECESSARY

HOW MANY (TOTAL) HOURS WORKED _____ AND/OR HOW MANY (TOTAL DAYS) _____ PER YEAR DO YOU PROVIDE LOCUM TENENS COVERAGE?

INSTITUTION/PRACTICE NAME	CONTACT	CITY	STATE	FROM / /	TO / /
INSTITUTION/PRACTICE NAME	CONTACT	CITY	STATE	FROM / /	TO / /
INSTITUTION/PRACTICE NAME	CONTACT	CITY	STATE	FROM / /	TO / /
INSTITUTION/PRACTICE NAME	CONTACT	CITY	STATE	FROM / /	TO / /

PROFESSIONAL LIABILITY HISTORY

1. PRESENT OR PREVIOUS INSURANCE CARRIER

ADDRESS			CITY	STATE	ZIP
POLICY #	TYPE OF POLICY OCCURRENCE ❑ CLAIMS MADE ❑	POLICY LIMITS $ / $	RETRO DATE	START DATE	EXPIRATION DATE

2. PRESENT OR PREVIOUS INSURANCE CARRIER:

ADDRESS			CITY	STATE	ZIP
POLICY #	TYPE OF POLICY OCCURRENCE ❑ CLAIMS MADE ❑	POLICY LIMITS $ / $	RETRO DATE	START DATE	EXPIRATION DATE

3. PRESENT OR PREVIOUS INSURANCE CARRIER

ADDRESS			CITY	STATE	ZIP
POLICY #	TYPE OF POLICY OCCURRENCE ❑ CLAIMS MADE ❑	POLICY LIMITS $ / $	RETRO DATE	START DATE	EXPIRATION DATE

Name: _____

MISCELLANEOUS QUESTIONNAIRE

Please explain any "yes" answers on a separate sheet.

1.	Has your license to practice in any jurisdiction been limited, suspended, revoked, voluntarily surrendered, reprimanded, admonished, investigated for a complaint or placed under investigation, corrective action, consent order of probation, had limits on licensure issuance, been subject to letters of concern, notification of proposed actions or any other licensing board activity not related to issuance or renewal?	❑ YES ❑ NO
2.	Have you been denied a license by any licensing board, or have you withdrawn an application for license for any reason?	❑ YES ❑ NO
3.	Have you ever been denied certification by a specialty board or not been allowed to sit for an exam for any reason?	❑ YES ❑ NO
4.	Has your narcotics license ever been suspended, revoked, limited or voluntarily surrendered, put on probation, or has probation ever been revoked?	❑ YES ❑ NO ❑ N/A
5.	Have you ever been denied membership or renewal thereof, or been subject to disciplinary action, by any dental organization or entity?	❑ YES ❑ NO
6.	Have you failed to satisfactorily complete any portion of any training program or has your contract with any training program not been renewed for what should have been a subsequent year? (** If changed programs in good standing, please answer "NO" and provide an explanation for change in programs)	❑ YES ❑ NO**
7.	Are you now, or have you ever been, under sanction of investigation with regard to Medicare and/or Medicaid?	❑ YES ❑ NO ❑ N/A
8.	Has your employment at any location been suspended, terminated, or not renewed for any reason other than your own voluntary decision not to practice there any longer?	❑ YES ❑ NO
9	Have you ever been convicted of a felony or misdemeanor?	❑ YES ❑ NO
10.	Have you been asked to leave a locum tenens/per diem/travel/temporary work assignment prior to your contractedwork end date?	❑ YES ❑ NO
11.	Are you able to perform, all the essential functions of the Locum Tenens assignment/assignment with or without accommodation? *** If no, please explain.	❑ YES ❑ NO***

PROFESSIONAL LIABILITY QUESTIONNAIRE

1.	Do you have current malpractice insurance coverage?	❑ YES ❑ N/A – Training ❑ NO
2.	Have you EVER been denied professional liability coverage? * If yes, please explain.	❑ YES* ❑ NO
3.	Has there been any change in your practice/specialty in the last five (5) years? ** If yes, please explain.	❑ YES** ❑ NO
4.	Have judgments, settlements, or claims ever been made against you in any professional liability cases, are there any pending against you or any group or other professional entity of which you are a member? *** If yes, please indicate the number of previous and/or pending claims: _____ . Years incidents occurred: 1._____ 2._____ 3. _____ 4. _____ 5. _____ Please provide a detailed narrative of each claim on the attached claim/suit information form page 9.	❑ YES*** ❑ NO

HEALTH STATUS QUESTIONS

The following questions relate to your health status and affirmative answers are not a basis for automatic disqualification. Their purpose is to assist us in evaluating appropriate placements, to facilitate the high quality of medical care, and to assure that any necessary precautionns are in place (please attach additional sheets if necessary).

1.	Do you have any alcohol or substance abuse problems? * If yes, please explain.	❑ YES* ❑ NO
2.	Have you ever tested positive for tuberculosis or had a positive TB skin test? *** If yes, you may be required to provide a report of a current negative chest x-ray performed after a ppd and less than one year old.	❑ YES*** ❑ NO
3.	Have you been vaccinated for Hepatitis B?.	❑ YES ❑ NO

ELECTRONIC HEALTH RECORDS (EHR)/ELECTRONIC MEDICAL RECORDS (EMR)

Do you have experience with EHR/EMR?	❑ YES ❑ NO

Name: _____

RELEASE & AUTHORIZATION

By signing below, I certify that all information in this application is true and complete. All information is considered material and important. Should Medical Doctor Associates agree to be bound under the terms of this application to provide liability coverage, it is understood this policy is void if it is found that there was any attempt to mislead, defraud or lie about any information contained in this application.

I understand that Medical Doctor Associates may introduce me to various facilities in order to provide medical services through Medical Doctor Associates. I agree to work in such referred facilities only through Medical Doctor Associates for the period described in Medical Doctor Associates' contract except upon payment of a reasonable recruitment fee and as otherwise provided in Medical Doctor Associates' contract.

I authorize and release to Medical Doctor Associates and its agents, including CREDENT Verification& Licensing Services, any and all specific Military Service records from any and all branches of the Military and its cognate organizations (including but not limited to: Manpower Offices, Personnel Support Detachments and National Personnel Records Centers and their representatives) and all such data, documents and information whether or not it is otherwise privileged or confidential relating to my education, training, performance, personal character, ethics, rank, privilege and current status.

I authorize Medical Doctor Associates and its agents to consult with any persons, entities, institutions, and/or medical licensing boards including, but not limited to, the Federation of State Medical Boards, who can provide information or documents, privileged or confidential, relating to my professional competence, ethics, personal character and professional liability history; to provide information, both written and oral, regarding the status of any license which I have possessed; to obtain licensure or hospital privileges for me and to obtain any information , in good faith and without malice, and specifically consent to the release of such information. I also release Medical Doctor Associates from any liability arising out of any request for information, in accordance with this application, that it makes, or use of information it receives, from third parties regarding my professional competence, ethics, character and professional liability history.

A photocopy of this document shall be acceptable proof to anyone receiving it of my full authorization.

NAME (PRINTED)	
SIGNATURE	DATE

Medical Doctor ASSOCIATES

4775 PEACHTREE INDUSTRIAL BLVD., SUITE 300
BERKELEY LAKE GA, 30092
1.800.780.3500
FAX: 770.246.0882

Name: _____

DENTAL PROCEDURES/EXPERIENCE/SKILLS

Please check any of the following procedures you will perform:

- ❑ SPECIALTY
  - ❑ GENERAL DENTIST
  - ❑ ENDODONTIST
  - ❑ ORTHODONTIST
  - ❑ PEDIATRIC DENTIST
  - ❑ PERIODONTIST
- ❑ ENDODONTICS/PERIODONTICS
  - ❑ ROOT CANALS
  - ❑ IMPLANTS
  - ❑ SCALING AND ROOT PLANNING
  - ❑ EXTRACTIONS
  - ❑ MOLAR ENDODONTICS
- ❑ COSMETIC
  - ❑ CROWNS
  - ❑ PARTIALS
    - ❑ FIXED
    - ❑ REMOVABLE
  - ❑ DENTURES
  - ❑ VENEERS
  - ❑ WHITENING
- ❑ ORTHODONTICS
  - ❑ FUNCTIONAL APPLIANCES
  - ❑ INVISALIGN
  - ❑ ADJUNCTIVE THERAPY
- ❑ OTHER
  - ❑ PROCEDURES ON CHILDREN
    AGES:_____
  - ❑ NITROUS OXIDE SEDATION
  - ❑ CONSCIOUS INTRAVENOUS SEDATION
  - ❑ LOCAL ANESTHESIA
  - ❑ METH MOUTH TREATMENT
  - ❑ WORK WITHOUT ASSISTANT
  - ❑ TAKE, DEVELOP AND MOUNT X-RAYS

Name: _____

LOSS INFORMATION (IMPORTANT! COMPLETE FULLY)

Please complete the Loss Information Supplement for each written request, incident, claim or suite (A, B, OR C) below.
Report professionnal liability and malpractice related matters.

For questions B and C below, report all matters that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit.

A. Are you now, or have you ever been, involved in a claim or suit arising out or the rendering or failure to render professional services?
❑ YES If Yes, how many? _____ ❑ NO

B. Are you aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably result in a claim or suit against you? This includes, but is not limited to the following: Amputation, Death, Loss of Major Organ Function, Loss of Vision, Permanent Neurological Injury.
❑ YES If Yes, how many? _____ ❑ NO

C. In the last 12 months, have you or anyone from your practice received a written request from an attorney for treatment records concerning any of your current or former patients that might reasonably result in a claim or suit against you?
❑ YES If Yes, how many? _____ ❑ NO

IF REPORTED TO YOUR INSURER, PLEASE PROVIDE A COPY OF THE REPORT(S).

A. Please fully explain any "YES" answers:

1. Do you treat or review treatment of Federal prison inmates?	❑ **YES** ❑ **NO** ❑ **N/A**
2. Have you ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance other than traffic offenses or had your DEA license, medical license or Medicaid/Medicare privileges revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered? If yes, please indicate the date(s):_____	❑ **YES** ❑ **NO** ❑ **N/A**
3. Have you had any professional liability insurance refused, canceled or non-renewed?	❑ **YES** ❑ **NO** ❑ **N/A**
4. Have you incurred or become aware of having a condition that impairs your ability to practice your specialty? (e.g. convulsive disorders, mental illness, multiple sclerosis, rheumatoid arthritis, addiction of alcohol, narcotics or other controlled substances, etc.)	❑ **YES** ❑ **NO** ❑ **N/A**

If YES, state condition, date(s) and identify your treating physician in the space provided below. In the event of any such impairment, **a statement from your physician attesting to your fitness to practice your specialty must accompany this application.** Further statements may be requested as necessary by the Company to complete the underwriting of your application.

TYPE	DURATION	TREATING PHYSCIAN (NAME & ADDRESS)

STATE STATUTORY REQUIREMENT

NOTE: All applicants must read and initial the following:
Any person who knowingly files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and also punishable by criminal and/or civil penalties in certain jurisdictions.

INITIAL HERE

PLEASE READ AND SIGN

I hereby declare that the above statements and particulars are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application shall be the basis of the contract with the Company. I agree to notify the Company if there is any future material change in any answer to this application, including without limitation, any change in my professional specialty, affiliation, or working arrangement with any physician or dentist, firm, or professional association.

I UNDERSTAND THAT ANY MATERIAL MISREPRESENTATION OR OMISSION MADE BY ME ON THIS APPLICATION MAY ACT TO RENDER ANY CONTRACT OF INSURANCE NULL AND WITHOUT EFFECT OR PROVIDE THE COMPANY WITH THE RIGHT TO RESCIND IT. BY MAKING THIS APPLICATION, I AM NOT RELYING UPON ANY ORAL OR WRITTEN REPRESENTATION THAT COVERAGE HAS OR WILL BE EXTENDED TO ME OR THAT A POLICY OF INSURANCE WILL BE ISSUED.

Date Signed: _____ Signature: _____

Print Name: _____

Name: _____

CLAIM/SUIT INFORMATION (A Page 9 is required for each claim/suit reported)

If making additional copies, please enter applicants name here:

NOTE: ADDITIONAL DOCUMENTATION (OFFICE,HOSPITAL RECORDS) MAY BE REQUESTED BY THE UNDERWRITING DEPARTMENT.

1. Claimant Information – Age: _____ Gender: ❑ Male ❑ Female
2. Date of treatment and/or surgery, that led to the allegations against you: _____
3. Date claim/incident notice received (MM/YY): _____ / _____
4. Date claim reported to prior insurer (MM/YY): _____ / _____
5. Name of other doctor(s), hospital(s) or health care provider(s), if any, involved in the claim or suit:

_____

6. Disposition or current status of claim or suit ❑ Open ❑ Closed Date of Closing/Settlement or award (MM/YY): _____ / _____
7. Indicate case value established by carrier if known (in $): _____
8. Defending Insurance carrier name: _____
9. Claim file number, if known: _____
10. Was this matter closed with your consent? ❑ Yes ❑ No
    Was a claim made or a suit filed? ❑ Yes ❑ No
    Was payment made? ❑ Yes ❑ No
    If no, was claim or suit withdrawn? ❑ Yes ❑ No
    If yes, indicate total amount of settlement or award (in $): _____
    Amount paid on your behalf (in $): _____
11. Nature of allegations in the claim or suit:
    Condition treated: _____
    Treatment provided: _____
    Alleged negligence: _____
    Alleged injury: _____
12. Please provide a narrative description of the medical facts: (must include, but not limited to the type of treatment and/or surgery; your involvement).

Name: _____

US Government Small Business Administration Subcontractor Survey & Attestation

- ❑ This form is not applicable (N/A) since I will be paid under my SSN
- ❑ If you are paid under a FEIN, but categorized as a large business, complete the top section and mark the N/A box under Classifications and sign the bottom of the form.

Please mark EVERY category that applies to your corporation using the definitions at the bottom of the form.

BUSINESS INFORMATION (PLEASE COMPLETE ALL BLANKS)		
BUSINESS NAME		TAX ID #
ADDRESS		
CITY	STATE	ZIP

CLASSIFICATIONS (PLEASE CHECK ALL THAT APPLY - IF NONE APPLY, CHECK HERE FOR N/A)	
❑ Small Business	❑ Small Disadvantaged Business
❑ Veteran-Owned Business	❑ Women-Owned Business
❑ Service-Disabled Veteran-Owned Business	❑ HUBzone Business

"Small Business Concern" means a concern, including its affiliates, that is independently owned and operated, not dominant in the field of operation which it is bidding in Government contracts or subcontracts, and meets the criteria and size standards published in Section 19.102 of the Federal Acquisition Regulation or 13 CFR, part 121. (For physicians - NAICS Classification Codes are Sector 62, Sub-sector 621 and small business is defined as less than $10 million in revenue).

"Veteran-Owned Concern" means a small business concern that is at least 51 percent owned and controlled by a U.S. Veteran or Veterans as defined in 38 United States Code (U.S.C) 101 possessing a discharge other than dishonorable. The management and daily business operations of which are controlled by one or more veteran.

"Small-Disabled Veteran-Owned" means a veteran with a disability that is service connected (as defined in section 101 (16) of title 38 U.S.C) and the small business is at least 51 percent owned and controlled by a US Veteran or Veterans possessing a discharge other than dishonorable. The management and daily business operations of which are controlled by one or more serviced-disabled veteran or, in the case of a veteran with permanent and sever disability, the spouse or permanent caregiver of such veteran.

"Small Disadvantaged Business Concern" means a small business concern that (a) is at least 51 percent owned by one or more individuals who are both socially and economically disadvantaged, or a publicly owned business having at least 51 percent of its stock owned by one or more socially and economically disadvantaged individuals and (b) has its management and daily business controlled by one or more such individuals.

"Socially disadvantaged individuals" means individuals who have been subjected to racial or ethnic prejudice or cultural bias because of their identity as a member of a group without regard to their qualities as individuals.

"Economically disadvantaged individuals" means socially disadvantaged individuals whose ability to compete in the free enterprise system is impaired due to diminished opportunities to obtain capital credit as compared to others in the same line of business who are not socially disadvantaged. Individuals who certify that they are Black Americans, American Indians, Eskimos, Aleuts, Native Hawaiians or U.S. citizens whose origins are in India, Pakistan, Bangladesh, Japan, China, the Philippines, Viet Nam, Korea, Samoa, Guam, the U.S. Trust Territory of the Pacific Islands, North Mariana Islands, Laos, Cambodia or Taiwan are considered socially and economically disadvantaged.

"Small Women-Owned Business Concern" means a small business concern that is at least 51 percent owned by a woman, or women, who are U.S. Citizens and who also control and operate it. Control in this context means actively involved in the day-to-day management.

"Historically Underutilized Business Zone (HUBZone)" means a concern that appears on the list of HUBZone Small Business Concerns maintained by the Small Business Administration. Only companies certified by the SBA are eligible for HUBZone status.

I attest that the above information is accurate and true to the best of my knowledge.

Name _____ Signature _____ Date _____

Erecruit ID _____

Name: _____

TRAVELER PROFILE

PASSENGER INFORMATION

Please enter all identifying information as it appears on your drivers license and/or passport

LAST NAME	FIRST NAME	MIDDLE NAME
GENDER ◉ MALE ❑ FEMALE	DATE OF BIRTH	

HOME ADDRESS	CITY	STATE	ZIP
WORK PHONE	HOME PHONE	CELL PHONE	

COPY ITINERARY TO

AIR TRAVEL PREFERENCES

SEATING PREFERENCE (CHECK ONE) ❑ AISLE ❑ WINDOW ❑ OTHER

MEAL REQUEST

SPECIAL REQUIREMENTS

FREQUENT FLYER

PROGRAM:	NUMBER:

HOTEL STAY PREFERENCES

ROOM TYPE:

OTHER ROOM PREFERENCES:

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT

PHONE

CELL PHONE

PLEASE FORWARD TO THE MDA TRAVEL DEPARTMENT

Name: _____

MedicalDoctor ASSOCIATES

New Vendor/EFT Direct

Please complete all fields and attach W-9.

ERECRUIT PROVIDER ID		
PROVIDER NAME		
PROVIDER SSN OR FEIN		
ADDRESS		
CITY	STATE	ZIP
ACCOUNT TYPE: ❑ CHECKING ❑ SAVINGS		
BANK NAME:		
ROUTING NUMBER:		
ACCOUNT NUMBER:		

Name: _____

DISCLOSURE AND AUTHORIZATION

Medical Doctor Associates may obtain information about you from a consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews with sources. These reports may be obtained at any time after receipt of your authorization and, if you are hired, throughout your employment. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your criminal history, education and/or employment history conducted by Accutrace, Inc. P.O. Box 624, Bryn Mawr, PA 19010 or by contacting us at 1-888-54 -TRACE or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing Employer to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and, if you are hired, throughout the course of your employment is limited to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any investigative consumer report.

New York applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by Employer by contacting the consumer reporting agency identified above directly.

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" at any time after receipt of this authorization and, if I am hired, throughout my employment. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by Accutrace, Inc. or another outside organization acting on behalf of Employer, and/or Employer itself. I agree that a facsimile ("fax") or photographic copy of this Authorization shall be as valid as the original.

Minnesota and Oklahoma applicants or employees only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company.

California applicants or employees only: By signing below, you also acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report if one is obtained by the Company at no charge whenever you have a right to receive such a copy under California law.

< Please Print Clearly >

APPLICANT'S NAME	EMAIL		
MAIDEN NAME(S) USED	NICKNAME(S) USED		
SOCIAL SECURITY NUMBER			DATE OF BIRTH (MM/DD/YYYY)
DRIVER'S LICENSE NUMBER			STATE
PROFESSIONAL LICENSE/CERTIFICATE NUMBER	STATE		PROFESSION
SCHOOL/UNIVERSITY NAME	DEGREE/DIPLOMA TYPE		DATE RECEIVED
CURRENT ADDRESS	CITY	STATE	ZIP
NO. OF YEARS AT CURRENT ADDRESS			
SIGNATURE			
ADDRESS:	CITY:	STATE:	ZIP:
ADDRESS	CITY:	STATE:	ZIP:

ACCUTRACE, INC. | P.O. BOX 624 | BRYN MAWR, PA 19010 | PHONE: 484-381-3200 | TOLL FREE: 888-54 TRACE | WWW.ACCU-TRACE.COM

FAX: 888-658-8608

Name: _____

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from FATCA reporting code (if any)

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here **Signature of U.S. person ▶** **Date ▶**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.