2800 Corporate Drive, Ste. 101, Flower Mound TX 75028
(p) 1-844-679-7050 (f) 1-866-806-3740

Primary Flint Information:

Provider Name: _____

Mailing Address: _____

Phone: _____ Cell: _____ Fax: _____

Email: _____

Emergency Contact: _____

Phone Number: _____

Social Security Number: _____

Place of Birth: _____

Citizenship: _____

If not American Citizen, Visa Number & Status: _____

Primary Specialty: _____

Board Certified? _____

Name of Certifying Board: _____

Expiration Date, If Applicable: _____

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(p) 1-844-679-7050 (f) 1-866-806-3740

Please provide copies of:

- Curriculum Vitae (CV)
- Standardized Credentialing Application (If applicable)
- Medical School/ Internship/ Residency Diplomas
- Fellowship (If applicable)
- ECFMG (If applicable)
- Board Certificate (If applicable)
- CME's (taken within the last 2 years)
- Color Copy of Driver's license with visible picture
- National Provider Identifier (NPI Number)
- State Medical License
- State DEA License
- ACLS
- ATLS
- PALS
- Badge Photo (Jpeg)

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(p) 1-844-679-7050 (f) 1-866-806-3740

The following items are attached in this packet:

- Peer Reference List
- TSA Pages 8-12 – (If Applicable, only if working in state of Texas)
- Immunity and Release
- Health Letter (to be signed by another physician)
- Immunization History (please complete and provide records)
- W-9
- Flint's Provider Service Agreement (PSA)
- Direct Deposit Form & Voided Check

**** Please return credentials via fax, email, or mail ****
Mailing Address: 2800 Corporate Drive, Ste. 101 ,
Flower Mound, TX 75028
Phone: 844-679-7050 Fax: 866-806-3740
Email:credentialing@flintmedicalstaffing.com

2800 Corporate Drive #101, Flower Mound, TX 75028
(p) 1-844-679-7050 (f) 1-866-806-3740

PEER REFERENCES

1) Name: _____

   Phone: _____

   Fax/Email: _____

   Address: _____

2) Name: _____

   Phone: _____

   Fax/Email: _____

   Address: _____

3) Name: _____

   Phone: _____

   Fax/Email: _____

   Address: _____

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(p) 1-844-679-7050 (f) 1-866-806-3740

IMMUNITY AND RELEASE

I understand and agree that I am in the process of applying to provide medical services on behalf of a professional corporation managed by Flint Medical Staffing, Inc. (Company), or its affiliates and subsidiaries, through a series of management agreements and that no agreement will be effective until this occurs.

I authorize Flint Medical Staffing, Inc. to contact the references listed and to conduct a customary investigation of my professional background and personal history, including contacting sources not listed by me. A photocopy of this authorization shall be as valid as the original.

I hereby release and hold harmless from and against any and all liability all representatives of Flint Medical Staffing, Inc., and/or Company, or its affiliates and subsidiaries, the Facility(ies), or its medical staff, for their acts and communications performed in good faith and without malice in connection with evaluating my application, credentials, and organizations who provide information to Flint Medical Staffing, Inc. and/or Company, or its affiliates and subsidiaries, the Facility(ies), or its medical staff, in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for employment, clinical privileges, and staff appointment. I hereby consent for the release of such information.

_____
DATE

_____
PLEASE PRINT NAME CLEARLY

_____
SIGNATURE

2800 Corporate Dr. #101, Flower Mound, TX 75028
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HEALTH LETTER

I do hereby certify that I have examined _____ and consider him/her to be in satisfactory physical health and able to carry out the duties necessary in the performance of his/her profession.

Any limitation or restriction placed on this healthcare professional are as follows:

_____

_____

_____

_____

_____
Examining Physician (please print)

_____
Signature

_____
Date

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(p) 1-844-679-7050 (f) 1-866-806-3740

IMMUNIZATION FORM

A copy of your immunization record will also be required with this completed form. Check one box in each section.

Name_____ Date_____

Varicella

- ☐ Documentation of vaccine or immunity Date_____
- ☐ Medical/Religious
- ☐ Had Disease
- ☐ Decline due to reasons of conscience

MMR

- ☐ Documentation of vaccine or immunity Date_____
- ☐ Medical/ Religious
- ☐ Had Disease
- ☐ Decline due to reasons of conscience

Tdap

- ☐ Documentation of vaccine or immunity Date_____
- ☐ Medical/ Religious
- ☐ Had Disease
- ☐ Decline due to reasons of conscience

Hepatitis B Vaccine (Hepatitis A/B Vaccine)

Date_____

- ☐ Documentation of vaccine or immunity
- ☐ Medical/ Religious
- ☐ Had Disease
- ☐ Decline due to reasons of conscience

Flu

Date_____

- ☐ Documentation of vaccine or immunity
- ☐ Medical/Religious
- ☐ Decline due to reasons of conscience

TB Skin Test (Required Yearly)

- ☐ Documentation of vaccine or immunity Date_____

Signature:_____

flint medical staffing

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(p) 1-844-679-7050 (f) 1-866-806-3740

COBRA/EMTALA

THE "20 Commandments" of COBRA/EMTALA

1. THOU SHALL: Log in every patient who presents, together with complaint/diagnosis and disposition. A patient presents when they enter into a dedicated emergency department of the hospital, including remote sites, or upon the campus within 250 yards of the main buildings seeking care or under circumstances when a reasonable layperson would conclude that the patient required care or evaluation for an emergency medical condition. A dedicated emergency department includes the hospital emergency department, OB department, and other departments and remote sites that see 1/3rd of their patients on a walk-in basis for assessment of emergency medical conditions or have a name that suggests that patients should seek care there or are held out to the public as such—i.e. urgent care, immediate care, or by broad adverting references in print or electronic form.

2. THOU SHALL: Provide a medical screening examination (MSE) by physician IN THE HOSPITAL OR DEDICATED EMERGENCY DEPARTMENT SITE, beyond triage, to all patients regardless of acuity who present as specified in #1, above. The MSE is an on-going process sufficient to reach a definitive exclusion of legally defined emergency medical conditions and is NOT a fixed point in the evaluation that allows termination of services or redirection of the patient to other sites.

3. THOU SHALL NOT; Delay the MSE in order to obtain financial information or induce the patient to leave without MSE by drawing payor issues or financial demands to the attention of patient or family prior to the completion of the MSE and initiation of stabilizing care. Care may not be denied based on denial of pre-authorization. Financial questions, documents, and preauthorization are at your own peril.

4. THOU SHALL: As a portion of the MSE, provide necessary testing within the capability of the hospital (including on-call services) as needed to exclude the presence of a legally defined emergency medical condition. Testing necessary for exclusion may not be deferred to more convenient times or locations. Abnormal findings should be normalized via treatment and documented by serial values or explained away prior to discharge.

5. THOU SHALL: To the extent of the capabilities of the hospital and/or the dedicated emergency department located off-campus, provide stabilizing care, such that the patient is not likely to deteriorate from or during transfer or discharge. In the case of OB patients with contractions present, the patient is deemed unstable until contractions cease or baby and placenta are delivered. If the site is not capable of appropriate stabilization, a medically appropriate transfer must be effected.

6. THOU SHALL; Provide on-call coverage schedules listing on-call physicians by individual name for all medical specialties generally engaged in the delivery of care necessary to serve the community needs under Medicare Conditions of Participation; to provide policies and procedures for cross-coverage, back-up or transfer for occasions when an on-call physician is not on-call or is unable to respond due to circumstances beyond their control; and to maintain the list for 5 years for enforcement purposes. On-call physicians may not decline to accept patients for evaluation or treatment in the dedicated emergency department for acceptance of EMTALA transfer.

7. THOU SHALL: Require on-call specialists to respond to the hospital to attend the patient in timely manner and to provide legally stabilizing care (generally definitive care) to presenting patients and those being transferred to a higher level of care under EMTALA. This obligation exists without regard to means or ability to pay. The hospital must enforce this obligation by necessary policies, procedures, bylaws, and enforcement actions including actions against the privileges of physicians who violate this obligation.

8. THOU SHALL: Transfer all EMTALA patients for only services or care not available at your facility or upon patient request documented to EMTALA requirements and ACCEPT TRANSFERS of patients for specialty services not available at the hospital where they originally presented.

9. THOU SHALL: Provide MSE to OB patients, patients with undiagnosed acute pain, symptoms of substance abuse, or symptoms of psychiatric disturbances sufficient to first rule out general medical, toxic, or traumatic conditions and thereafter to adequately evaluate and treat these specific conditions.

10.THOU SHALL: Obtain and document advanced acceptance from the receiving hospital.

11. THOU SHALL: Provide physician certification that the risks of transfer are outweighed by benefits of transfer prior to transfer to another facility and list the specific risks and benefits to this specific patient. Discharge instructions to go to another facility are improper transfers under EMTALA.

12. THOU SHALL: Provide transfer by medically appropriate vehicles, personnel and life support equipment to the destination hospital. A private auto does not meet these standards, even if the physician thinks is acceptable, unless the patient has signed a refusal of ambulance.

13. THOU SHALL: Provide medical records, labs, reports, and consultation records to accompany the patient on EMTALA transfers.

14. THOU SHALL; List the name of any on-call physician who refused or failed to respond in timely manner, thereby requiring the patient to be transferred for necessary evaluation or care.

15. THOU SHALL: Obtain written consent to transfer from the patient or responsible party or provide reasonable documentation to justify the failure to obtain written consent.

16. THOU SHALL: Obtain written refusal of services by a patient –if able- and if not able, from a responsible person-if the patient/person refuses, exam, treatment, ambulance or transfer. The refusal must contain specific risks of refusal and the advantages of consent.

17. THOU SHALL: Document all history, physical exam, monitoring and interventions provided to the patient. Failure to document intake and discharge vitals are not mandated by EMTALA but have repeatedly results in citations for inadequate assessment where both intake and discharge vitals are not noted. Failure to document is a violation of Medicare conditions of participation and is frequently the basis of citations.

18. THOU SHALL: Periodically reassess patients as their category or condition warrants and document those observations in the record. Failure to reassess during extended waiting times and during the course of treatment frequently results in citation.

19. THOU SHALL: Post EMTALA signs in all public entrances, waiting areas, registration and care areas in any area of the hospital or remote site that qualifies as a dedicated emergency department under EMTALA.

20. THOU SHALL: Report any suspected, possible violations of EMTALA by another facility that results in your facility improperly receiving a patient without EMTALA compliance or in refusal of transfer of a patient of your hospital by an appropriate destination hospital with specialized services not available at your facility.

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For informational and educational purposes only. Be certain to consult your hospital counsel for legal advice regarding policies, procedures and legal obligations under this and other laws.

I HAVE READ AND UNDERSTAND THE COBRA/EMTALA RULES AND REGULATIONS AS PROVIDED TO ME BY FLINT MEDICAL STAFFING.

SIGNED: _____ DATE: _____

Frew, Stephen A. FD. "The 20 Commandments of EMTALA." MedLaw.com. Frew Consulting Group, Version 4.0 Copyright 1998-2005. www.medlaw.com. April 15, 2015 article was accessed. http://www.medlaw.com/healthlaw/EMTALA/education/the-20-commandments-of-em~print.shtml.

Section II-Disclosure Questions - Please *provide* an explanation for any question answered yes-except 16-on page 10.

Licensure

1 Has your license to practice, in your profession, ever been denied, suspended, revoked, restricted, voluntarily surrendered while under investigation, 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 received a reprimand or been fined by any state licensing board?

☐ Yes ☐ No

Hospital Privileges and Other Affiliations

3 Have your clinical privileges or Medical Staff membership at any hospital or healthcare institution ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical records when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?

☐ Yes ☐ No

4 Have you voluntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?

☐ Yes ☐ No

5 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

6 Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?

☐ Yes ☐ No

7 Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?

☐ Yes ☐ No

8 Have any of your board certifications or eligibility ever been revoked?

☐ Yes ☐ No

9 Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?

☐ Yes ☐ No

DEA or DPS

10 Have your Federal DEA and/or DPS Controlled Substances Certificate(s) or authorization(s) ever been denied, suspended, revoked, restricted, denied renewal, or voluntarily relinquished?

☐ Yes ☐ No

Medicare, Medicaid or other Governmental Program Participation

11 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

12 Are you currently or have you ever been the subject of an investigation by any hospital, licensing authority, DEA or DPS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program?

☐ Yes ☐ No

Section II - Disclosure Questions - *continued*

Other Sanctions or Investigations

13 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

14 Have you ever received sanctions from or been the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?

☐ Yes ☐ No

15 Have you ever been investigated, sanctioned, reprimanded or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation by a hospital or healthcare facility of any military agency?

☐ Yes ☐ No

Malpractice Claims History

16 Have you had any malpractice actions within the past 5 years (pending, settled, arbitrated, mediated or litigated?

☐ Yes ☐ No

☐ *If yes, please check this box and complete and submit Attachment G.*

Criminal

17 Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony that is reasonably related to your qualifications, competence, functions, or duties as a medical professional

☐ Yes ☐ No

18 Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony including an act of violence, child abuse or a sexual offense?

☐ Yes ☐ No

19 Have you been court-martialed for actions related to your duties as a medical professional?

☐ Yes ☐ No

Ability to Perform Job

20 Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drug may have an ongoing impact on one's ability to practice medicine. 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 Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)

☐ Yes ☐ No

21 Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?

☐ Yes ☐ No

Ability to Perform Job

22 Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients?

☐ Yes ☐ No

23 Are you unable to perform the essential functions of a practitioner in your area of practice, with or without reasonable accommodation?

☐ Yes ☐ No

Please use the space on page 10 to explain yes answers to any question except #16.

Section III – Standard Authorization, Attestation and Release (Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation and/or clinical privileges (hereinafter, referred to as "Participation") at or with

(PLEASE INDICATE MANAGED CARE COMPANY(S) OR HOSPITAL(S) TO WHICH YOU ARE APPLYING) (HEREINAFTER, INDIVIDUALLY REFERRED TO AS THE "ENTITY")

and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

For Hospital Credentialing. I consent to appear for an interview with the credentials committee, medical staff executive committee, or other representatives of the medical staff, hospital administration or the governing board, if required or requested. As a medical staff member, I pledge to provide continuous care for my patients. I have been informed of existing hospital bylaws, rules and regulations, and policies regarding the application process, and I agree that as a medical staff member, I will be bound by them.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning: (I) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third

APPLICANT'S INITIALS AND DATE (MM/DD/YYYY)

Section II - Disclosure Questions-*continued*

Please use the space below to explain yes answers to any question except 16.

QUESTION NUMBER	PLEASE EXPLAIN

Section III – Standard Authorization, Attestation and Release – continued

party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities.

In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is true, correct, and complete to the best of my knowledge and belief, and that I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted on-line or in writing, and must be dated and signed by me (may be a written or an electronic signature). I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s).

I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

SIGNATURE

NAME (PLEASE PRINT OR TYPE)

Last 4 digits of SSN or NPI (PLEASE PRINT OR TYPE)

DATE (MM/DD/YYYY)

Required Attachments or Supplemental Information – Please attach hard copy or scanned documents of the following:

- ☐ Copy of DEA or state DPS Controlled Substances Registration Certificate
- ☐ Copy of other Controlled Dangerous Substances Registration Certificate(s)
- ☐ Copy of current professional liability insurance policy face sheet, showing expiration dates, limits and applicant's name
- ☐ Copies of IRS W-9s for verification of each tax identification number used
- ☐ Copy of workers compensation certificate of coverage, if applicable
- ☐ Copy of CLIA certifications, if applicable
- ☐ Copies of radiology certifications, if applicable
- ☐ Copy of DD214, record of military service, if applicable

Notice About Certain Information Laws and Practices Pertaining to State Governmental Bodies (i.e. State Hospitals)

With few exceptions, you are entitled to be informed about the information that a state governmental body collects about you (i.e. a state hospital). Under sections 552.021 and 552.023 of the Texas Government Code, you have a right to review or receive copies of information about yourself, including private information. However the state governmental body may withhold information for reasons other than to protect your right to privacy. Under section 559.004 of the Texas Government Code, you are entitled to request that the state governmental body correct information that it has about you that is incorrect. For information about the procedure and costs for obtaining information, please contact the appropriate state governmental body to which you have submitted this application.

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.

2800 Corporate Drive #101, Flower Mound, TX 75028
(p) 1-844-679-7050 (f) 1-866-806-3740

VENDOR DIRECT DEPOSIT ENROLLMENT FORM

To enroll in Direct Deposit, simply fill out this form and return it by mail or email*:

Flint Medical Staffing
2800 Corporate Dr. #103
Flower Mound, TX 75028

office@flintmedicalstaffing.com

*Enrollment forms must be received by the end of the shift's pay period in order to be processed for deposit; otherwise a paper check will be issued and the direct deposit will not be effective until the next scheduled deposit.

IMPORTANT! Please read and sign before completing and submitting.

I hereby authorize Flint Medical Staffing (hereinafter "FMS") to deposit any amounts owed me by initiating credit entries to my account at the financial institution (hereinafter "Bank") indicated on this form. Further, I authorize Bank to accept and to credit any credit entries indicated by FMS to my account. In the event that FMS deposits funds erroneously into my account, I authorize FMS to debit my account for an amount not to exceed the original amount of the erroneous credit. This authorization is to remain in full force and effect until FMS has received written notice from me of its termination in such time and in such manner as to afford FMS reasonable opportunity to act on it.

Provider Name: _____ Date: _____

Provider Signature: _____

Attach a voided check for each checking account - *not a deposit slip.* If depositing to a savings account, ask your bank to give you a letter with the Routing/Transit Number for your account. It isn't always the same as the number on a savings deposit slip. This will help ensure that you are paid correctly.

Account Type (circle one): Checking Savings

Bank Name: _____

Bank Address: _____

_____

Bank Phone Number: _____

Bank Routing Number: _____

Bank Account Number: _____

YOUR Email address (For Pay Documentation) _____

Flint Medical Staffing, Inc.

Locum Tenens Staffing Agreement

Provider Name

Effective Date

This Agreement is made by and between the above-named provider ("**Provider**") and Flint Medical Staffing, Inc. ("**Agency**"), established on the date above ("**Effective Date**"), to provide medical services on a sub-contractual basis for third party healthcare facilities ("**Clients**").

WHEREAS, Agency contracts with Clients to arrange for medical services to be provided on a Locum Tenens basis; and
WHEREAS, Provider desires to provide medical services as an Independent Contractor on a Locum Tenens basis to Clients of Agency; and
WHEREAS, Agency and Provider desire to set forth their Agreement relating to Locum Tenens opportunities;

THEREFORE:

General Terms

1.1 This agreement shall begin on the Effective Date and shall continue until terminated as set forth in this agreement or until a new agreement is entered into between Provider and Agency. Agreement shall automatically renew for successive periods of one year each unless either party sends written notice at least thirty (30) days prior to the end of the then active term.

1.2 Either party may terminate this Agreement, and Provider or Client may terminate an assignment with or without cause by giving at least thirty (30) days prior written notice. Provider agrees to provide Locum Tenens services at the location designated by Client during the entire notice period. Neither Agency nor Client shall be obligated to pay Provider for any scheduled services not actually performed by Provider during the notice period.

1.3 This Agreement may be terminated by Agency, at its discretion, without prior notice to Provider upon the occurrence of any of the following events:

a. Provider becomes disqualified to practice medicine in any state, or Provider's license or hospital privileges are revoked, suspended, or restricted, whether voluntarily or involuntarily.
b. Client which Provider is scheduled to provide services to requests that he/she be removed for reasons relating to competence or professional conduct, whether alleged or actual.
c. Provider fails to qualify or becomes ineligible for coverage under the terms of Agency's malpractice insurance policy.
d. Provider fails to perform the duties required by this Agreement, violates its terms, or otherwise refuses to cooperate with Agency.

e. Agency determines that Provider provided false and/or misleading information or omitted any relevant information on application materials in order to be misleading.

1.4 **Payment:** If Client fails to meet financial obligations to Agency for services performed by Provider, Provider understands that future assignments may be canceled. Agency may, at their own election, pay Provider for services rendered before Client issues payment to Agency. However, under no circumstances will Agency be obligated to pay for services for which Agency has not received payment from Client. Provider will also not be entitled to payment for any scheduled services not actually performed.

1.5 **Non-solicitation:** During the term of this agreement, and for a two (2) year period after this Agreement is terminated for any reason, Provider shall not solicit or make any offer to become employed by, involved or affiliated with, directly or indirectly, any Client of Agency whose need for coverage was disclosed to Provider by Agency or to facility Provider provided services pursuant to this Agreement unless otherwise agreed to in writing by Agency. Provider will not disclose information about opportunities presented to him/her by Agency to other agencies. For purposes of this Agreement, an "affiliate" of an entity includes, but is not limited to, an organization or person that is connected or allied with, has any form of direct or indirect relationship with, is comprised of one or more owners of, or is a successor or assignee of the entity.

1.6 **Recruitment:** During the two (2) year period after Agency presents Provider to a Client or Provider ceases to provide services to Client under this Agreement, whichever is later, Provider shall notify Agency within ten (10) days if Provider is recruited by or accepts a permanent position or Locum Tenens assignment with Client, Client affiliate, or facility where Provider's service was performed, or to whom Client refers Provider for the Client's benefit, Provider agrees that the Client shall be responsible for paying a reassignment fee. In the event the Client or other responsible third party refuses to pay such reassignment fee, Provider will either refuse the offer, or pay a reassignment fee of $30,000 to Agency plus any attorneys' fees incurred in the collection of such amounts.

1.7 **Independent Contractor Status:** Agency acts as a placement agent for Client and Provider is an Independent Contractor. Provider shall not be, for any purpose, treated as an employee or agent of Agency. Agency is not licensed to practice medicine and will not in any way attempt to influence or direct Provider's professional medical judgment or Provider's relationship with Clients or patients. Because Provider is not an employee of Agency, Provider agrees that Agency shall not provide health insurance, worker's compensation or unemployment benefits for Provider, and Agency shall not make or withhold tax payments for state or federal entities unless required by law. Agency shall deliver Provider a Form 1099 annually within the time required by law.

a. Provider acknowledges and agrees that (i) he/she is solely responsible for the filing and paying of all federal, state, and local income taxes and self-employment taxes due on the payments received from Agency or Clients of Agency; (ii) Agency is not a staff leasing service; (iii) available assignments will vary from time-to-time depending on the needs of Agency's Clients, and therefore, Agency does not and cannot guarantee specific dates, times, or hours of assignments; (iv) as an Independent Contractor, Provider has the flexibility to accept or decline an assignment for which he/she is selected and (v) Provider is not eligible to claim unemployment benefits or workers' compensation benefits and will not file any claim against Agency for unemployment or workers' compensation benefits. If Provider is unable to fulfill an assignment for any reason, Provider agrees to notify the appropriate Agency Representative immediately.

1.8 **Indemnification:** As an Independent Contractor, Provider is responsible for his/her own medical decisions and actions and hereby indemnifies Agency and shall hold Agency harmless from any losses, damages, liabilities, and expenses ("claims") not covered by the malpractice insurance, referred to in Section 2.5 herein, that are incurred by Agency arising out of, in connection with, or as a result of, Provider rendering or failing to render medical services during the term of this Agreement, including claims that Agency's negligence, in whole or part, caused the loss.

1.9 **Governing Law:** This Agreement shall be governed and interpreted in accordance with the laws of the State of Texas. Exclusive jurisdiction and venue of any dispute or legal action relating to this Agreement shall lie in the state or federal courts of Lubbock County, Texas.

1.10 **Amendments:** Any and all changes to this Agreement shall be agreed to, approved, and signed by both parties and only to the extent set forth therein.

1.11 **Notifications:** All notifications by Provider shall be in writing to Agency via certified mail or by another method mutually agreed upon by each party for the specific communication contemplated.

1.12 **Paragraph Headings:** The paragraph headings contained in this Agreement are for convenience only and shall in no manner be construed as part of this Agreement.

1.13 **Legal Construction:** In case of any one or more of the provisions contained in this Agreement is for any reason to be held to be invalid, illegal, or unenforceable in any respect, such invalidity, illegality, or unenforceability shall not affect any other provision thereof, and this Agreement shall be construed as if such invalid, illegal, or unenforceable provision had never been contained herein.

Payments and Expenses

2.1 **Daily Rates:** All rates will be negotiated and agreed between Provider and Client through Agency on an assignment by assignment basis with the assistance of Agency as agent. Rates may include any of the following, but none are guaranteed on any given assignment – Daily Rate, Hourly Rate, Overtime, Call Back, Pager, Holiday, or others as agreed. Agency shall establish all Rates with Provider prior to the assignment beginning and confirmed through a confirmation letter which is hereby incorporated into this Agreement by this reference. Provider shall notify Agency, according to the timeline stated in the confirmation letter, of any perceived error in the rates in the confirmation letter. If no such notice is given by the Provider, the rate in the confirmation letter will be deemed as accepted when the Provider starts the assignment.

2.2 **Timesheets:** Provider will submit a timesheet, which has been signed by the Client, to Agency by the deadline stated in the confirmation letter. If the Provider submits a timesheet after the deadline for submission, Agency will issue payment during the next regularly scheduled payroll cycle.

2.3 **Travel and Transportation:** When travel and transportation are necessary, Agency will incorporate a rate with Client that will allow Provider's expenses to be offset for travel and transportation to-and-from assignment. In some cases, Agency may contract with Client to provide travel and transportation separate from the base rate and will use its best effort to ensure that Client provides for round-trip travel to-and-from the assignment (in most instances prepaid airline tickets) and local transportation while Provider is in the community and on assignment. Under no circumstances is Agency liable to reimburse Provider for travel costs if such costs are not preapproved by Client or agreed upon in the confirmation letter.

2.4 **Housing:** If necessary, Agency will arrange for Client to provide Provider with reasonable and pleasant living accommodations while on assignment. Provider will be provided lodging for en route travel as needed and established in the confirmation letter. Provider will be reasonable for all personal expenses (e.g. meals, telephone calls, laundry, etc.). Agency reserves the right to cause amounts to be offset against advances for personal expenses by Agency or Client against amount due to Provider hereunder. Additionally, if an all-inclusive rate has been negotiated by Provider and Client, Provider is responsible for housing, not Agency.

2.5 **Insurance:** When providing services to Clients of Agency pursuant to this Agreement, Provider shall be insured under the terms of Agency's group malpractice insurance policy or similar insurance provided by Client. Subject to the terms and conditions of the policy, such malpractice insurance will cover Provider, if necessary, for any claim arising out of the rendering of, or failure to render professional services by Provider while on assignment under this Agreement regardless of when the claim is made. Upon expiration of the policy, Agency shall purchase tail coverage or prior acts coverage with the new policy. Provider shall provide all information required by Agency's group malpractice insurer to establish and maintain eligibility under the terms of the group malpractice insurance policy. Among other things, this coverage is contingent upon the information Provider submits to Agency being accurate and complete.

A. The cost of the malpractice insurance will be covered by Agency, unless: (i) Provider is assigned to a government-owned facility under a Personal Services Contract as will be set forth in a confirmation letter; or (ii) Provider agrees to provide services pursuant to this Agreement while being covered by comparable malpractice insurance through Provider or Client's own insurance carrier.
B. If Provider and Agency agree to terms for assignment wherein Provider is providing professional medical services under their own malpractice insurance, Provider hereby agrees to hold Agency harmless for any claims incurred, whether immediate or delayed, during such assignment. Provider should determine whether to acquire additional independent malpractice insurance coverage.

2.6 **Facility Privileging and Licensure:** Agency will assist Provider in requesting documentation necessary for facility privileging and state licenses. Provider agrees to provide timely and accurate information to Agency and Client to complete required privileging and/or state licensure applications on a timely basis. As part of obtaining necessary facility privileges, Provider may be required to submit to drug screening. Provider authorizes Agency to release to the Client any information required for facility privileges relating to an assignment, including the results of any drug screening. Provider will not be required to pay for any costs relating to obtaining any necessary privileges for an assignment.

Provider Covenants

3.1 **Standard of Care:** Provider shall provide medical services to patients of Client according to the laws and standards of practice among members of their same health care profession with similar training and experience in the community in which Provider performs services on behalf of Client.

3.2 **Services:** Provider agrees to devote full professional efforts while on assignment to provide medical services for client. Provider shall not compete with Agency's interests while on assignment. If Provider is requested to perform additional responsibilities for Client, affiliate of Client, or worksite of Client not covered under specific assignment, or Client refers Provider to any other facility for the benefit of the Client, Provider will not accept such additional dates or responsibilities without prior authorization from Agency. If Provider accepts such assignment without prior approval from Agency, Provider agrees that the assignment will be deemed to have been arranged by Agency, and that Agency shall be entitled to collect the recruitment fee as stated in Section 1.6 herein.

3.3 **Records:** Provider shall maintain customary medical records in accordance with standards and within the time period set by the healthcare facility or facilities for which Provider performs services pursuant to this Agreement and agrees that all such records shall be and remain the property of, and shall be processed and handled solely by, such Client. Provider agrees to complete all dictation for all progress notes, histories, physicals, and chart documentation prior to leaving the assignment as required by Client. Provider understands and agrees that Client has, at its discretion, the right to hold payment if such documentation is not completed upon assignments end.

3.4 **Billings:** During the term of this Agreement Provider shall assign all billings for services rendered by Provider to the Client for which Provider performs services and agrees that all billings for such services rendered shall be and remain the property of and shall be processed and handled solely by such Client. Provider agrees to assist Client in Client's bill collecting procedures including but not limited to timely furnishing of all information requested by Client. In connection with the processing and handling of billings by client, Provider hereby irrevocably grants to such Client the authority to endorse and deposit as appropriate all checks and other instruments or items that may be payable to Provider with respect to services rendered by Provider. In addition, Provider agrees to deliver to any bank or other financial institution designated by any such Client written evidence of the endorsement authority granted herein.

3.5 **Notification of Litigation:** Provider shall immediately notify Client and Agency in writing of any threatened or actual malpractice claims involving Provider, whether such claim took place before or during this Agreement or related to services in connection with this Agreement. Provider also agrees to notify Client and Agency immediately and in writing of any situation in relation to services provided under this Agreement that Provider has any reason to believe may lead to a malpractice claim. Provider understands and accepts that failure to comply with these terms may invalidate the malpractice liability insurance provided under this Agreement.

3.6 **Notification of Disciplinary Action:** Provider agrees to notify Client and Agency immediately of any disciplinary or quality assurance proceedings involving Provider (e.g., with licensing boards, quality assurance committees, hospitals or other healthcare facilities, medical societies, or of claims of suits). Provider also agrees to promptly notify Client and Agency in the event that such proceedings are pending or are instituted, whether or not they are related to professional services performed for a Client or Agency.

3.7 **Reproduction of Curriculum Vitae (CV):** In the course of presenting Provider to Clients for potential provision of contract services, Agency may reproduce the CV of Provider. Agency will use good faith efforts to prevent any errors in the reproduction of Provider's CV. Provider hereby agrees to release and hold Agency harmless from all liability for any errors made in such reproduction.

3.8 **Confidentiality:** Provider agrees that the terms of this Agreement are confidential and shall not be disclosed by Provider to any third parties.

The parties, both Agency and Provider, hereby execute this Agreement effective on the day and year first above written.

FLINT MEDICAL STAFFING, INC.	**PROVIDER**
_____	_____
Signature	Signature
_____	_____
Printed Name	Printed Name
_____	_____
Date	Date