Independence
Anesthesia Services

3722 Atlanta Highway, Suite 1, Athens, GA 30606
Toll Free (866) 427-6691 Fax (706) 425-8656
www.imedservices.com

INDEPENDENT CONTRACTOR AGREEMENT WITH RESTRICTIVE COVENANTS

This agreement is made this _____ day of _____ 201_____, between _____, d/b/a_____ (hereinafter called "the Contractor"), and Pro Nurse, Inc. d/b/a Independence Anesthesia Services (hereinafter called "the Agent").

In consideration of the mutual promises of the parties, and for other good and valuable consideration, and intending to be legally bound, the Contractor and the Agent agree as follows:

1. The Agent shall search for work assignments for the Contractor as a physician at hospitals and/or other health care related facilities. The Agent shall use its best efforts to negotiate the most competitive contract rates and/or remuneration on behalf of the Contractor.
2. The Contractor is free to accept or reject any work assignment offered by the Agent. The Contractor is free to perform services in addition to and outside of any work assignment offered by the Agent and agreed by the Contractor.
3. The Contractor shall have sole control over the manner and means of the services performed. The Contractor shall not be deemed an employee of the Agent for any purpose, including, but not limited to, any local, state, or federal laws regarding employment or compensation for employment. The Contractor shall be fully responsible for and shall furnish proof of liability insurance and current licensure by individual medical boards and applicable specialty certifications. The Contractor has full and sole responsibility for any and all applicable local, state, and federal income tax withholding, state and federal unemployment and disability insurance withholding and contributions, social security tax withholding and contributions, Medicare tax withholdings and contributions, and workers' compensation insurance. The Contractor agrees to accept sole responsibility for accuracy of all credentialing and licensure materials. The Contractor shall indemnify and hold harmless the Agent and Agent's responsible officers, partners, and directors from and against any and all liability for such obligations.
4. Any work assignment accepted by the Contractor will be completed in a professional manner. If the Contractor fails to complete a work assignment after having accepted the assignment, the Contractor shall be regarded as having breached this agreement.
5. During the term of this agreement, and for a period of one (1) year after the termination of this agreement, for any reason whatsoever, the Contractor shall not, directly or indirectly, accept any position at any hospital and/or any health care related facility in a manner designed to avoid payment to Agent of its fees if during the term of this agreement Agent informed Contractor of the availability of a work assignment at said facility. A breach or circumvention of this agreement shall entitle the Agent, in addition to any other rights and remedies available by law, or at equity, or otherwise, to an injunction to be issued by any court of competent jurisdiction, without filing of a bond, enjoining and restraining the Contractor from violating any of the provisions of this paragraph.
6. The Contractor authorizes the Agent and any of its associates or representatives to release any information the Agent determines may be material to the Contractor's placement including providing a curriculum vitae to perspective facilities and release Agent and any hospitals or healthcare facilities to which such information is disclosed, from and against any liability related thereto.

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7. In the event of a breach of this agreement, the Agent may, at its discretion:
   a. Terminate this agreement, and thereafter bring such action, as it may deem proper to protect its rights.
   b. Bring such action, including injunctive, as may be necessary to compel the Contractor to comply with his/her obligations under this agreement.
   c. Pursue such other remedies as may be available to it.
8. If the Agent initiates any proceedings, including injunctive, for breach of this agreement, the Contractor shall pay all costs and fees, including attorney's fees, associated with such proceedings. The parties agree that venue for any legal proceeding in this matter shall be in Oconee County, Georgia.
9. Either party may elect to terminate this agreement at any time, for any reason, with or without reason, notice, or cause, subject to the restrictions and obligations assumed under this agreement, provided, however, that the restrictions set forth in paragraph 5 shall be deemed to have no effect and shall be null and void if this agreement is terminated by the Agent within thirty (30) days after its execution. This agreement shall be fully enforceable if the Contractor terminates this agreement at any time for any reason.
10. The Contractor agrees that in the event a situation occurs while on a work assignment referred by the Agent, which could possibly lead to a threat of a malpractice suit, the Contractor will ensure that proper notice is given to the insurance carrier.
11. Both parties agree that a facsimile, photocopy, or similar duplication of this agreement is as valid as the original.

IN WITNESS THEREOF, the parties execute this agreement understanding they shall be legally bound.

IAS Authorized Representative Sign: _____ **Date:** _____

IAS Authorized Representative Print: _____

Independent Contractor Sign: _____ **Date:** _____

Independent Contractor Print: _____

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Physician Application

Personal Information				
Last Name	First Name	Middle Name	Suffix	Degree
Social Security Number	Date of Birth	Previous Names		
Citizenship	Birth City	Birth State		
Home Phone	Cell Phone	Office Phone		
Home Fax	Office Fax	Email Address		

Education			
Medical School	Degree	From (mm/yy)	To (mm/yy)
City	State		
Internship (PGYI) Facility Name		From (mm/yy)	To (mm/yy)
City	State	Specialty	
Residency Facility Name		From (mm/yy)	To (mm/yy)
City	State	Specialty	
Fellowship Facility Name		From (mm/yy)	To (mm/yy)
City	State	Specialty	
Additional Training Facility Name		From (mm/yy)	To (mm/yy)
City	State	Specialty	
Additional Training Facility Name		From (mm/yy)	To (mm/yy)
City	State	Specialty	

Board Specialty					
Specialty Board	Board Certified ☐	Board Eligible ☐	Date Certified	Certificate Number	Recert Date
Specialty Board	Board Certified ☐	Board Eligible ☐	Date Certified	Certificate Number	Recert Date

Provider Numbers	
Federal DEA Number and Expiration	NPI Number
Medicare # and State	Medicaid # and State
BCBS # and State	Champus # and State

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Physician Application

Foreign Graduates

Do you have a permanent ECFMG Certificate? ☐ Yes ☐ No	ECFMG Certificate Number

Licensing Exams

National Boards ☐ Yes ☐ No Date Taken:	FLEX ☐ Yes ☐ No Date Taken:	SPEX ☐ Yes ☐ No Date Taken:
USMLE ☐ Yes ☐ No Date Taken:	State Boards ☐ Yes ☐ No Date Taken:	LMCC ☐ Yes ☐ No Date Taken:

Licensure (Please list all licenses ever held. Use additional sheets if necessary.)

State	License Number	Status	Original Issue Date	Expiration Date	Controlled Substance Number
		☐ Active ☐ Original License ☐ Inactive			
		☐ Active ☐ Inactive			
		☐ Active ☐ Inactive			
		☐ Active ☐ Inactive			
		☐ Active ☐ Inactive			
		☐ Active ☐ Inactive			
		☐ Active ☐ Inactive			
		☐ Active ☐ Inactive			
		☐ Active ☐ Inactive			
		☐ Active ☐ Inactive			

References (Please list 4 physician references known to you within the last year that are able to comment on your capabilities.)

Name	Position	Phone Number
Address	City, State, Zip	Fax Number or Email Address
Name	Position	Phone Number
Address	City, State, Zip	Fax Number or Email Address
Name	Position	Phone Number
Address	City, State, Zip	Fax Number or Email Address
Name	Position	Phone Number
Address	City, State, Zip	Fax Number or Email Address

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Physician Application

If the answer to any question is "yes", please provide a detailed explanation and necessary documentation.	
☐ Yes ☐ No	Have any disciplinary actions been initiated or are any pending against you by any state licensure board, institution, professional society, or healthcare facility?
☐ Yes ☐ No	Has your license to practice in any state ever been (voluntarily or involuntarily) denied, limited, reduced, suspended, reprimanded, placed on probation, not renewed, relinquished, or revoked?
☐ Yes ☐ No	Have you ever been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program (for example: HMO, PPO, PHO, Medicare, Medicaid)?
☐ Yes ☐ No	Have you ever been the subject of an investigation by any private, federal, or state agency concerning your participation in any private, federal, or state health insurance program (for example: HMO, PPO, PHO, Medicare, Medicaid)?
☐ Yes ☐ No	Have you ever been named as a defendant in any criminal proceeding?
☐ Yes ☐ No	Has your professional liability coverage ever been terminated by action of the insurance company? If yes, state when and by what company.
☐ Yes ☐ No	Have you ever been denied professional liability coverage or rated in a higher than average risk class for your professional specialty? If yes, state when and by what company.
☐ Yes ☐ No	Has any professional liability insurance carrier excluded any specific procedure from coverage? If yes, provide a detailed explanation including the name of the carrier, date, specific procedures excluded, and limitations.
☐ Yes ☐ No	Have any professional liability suits been filed against you?
☐ Yes ☐ No	Have any professional liability suits been filed against you which are presently pending?
☐ Yes ☐ No	Have any judgments or settlements been made against you in professional liability cases?
☐ Yes ☐ No	Have you been hospitalized any time during the past five years?
☐ Yes ☐ No	Are you currently under the care of a physician or psychologist?
☐ Yes ☐ No	Have you ever been denied health, life, or disability insurance?
☐ Yes ☐ No	Do you have any limitations on your health, life, or disability insurance?
☐ Yes ☐ No	Do you currently or have you ever had any problems with alcohol or drug dependency?
☐ Yes ☐ No	Do you presently use any illegal drugs?
☐ Yes ☐ No	Are you currently taking any medication that may affect your clinical judgment or motor skills?
☐ Yes ☐ No	Are you currently under any limitations concerning your activities or workload?
☐ Yes ☐ No	Do you presently have any physical, mental, or emotional condition which might affect your ability to perform the clinical privileges you are requesting?

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Physician Application

I hereby affirm that the information provided by me on this application and attachments is true, complete and correct and that Independence Anesthesia Services will rely on the truthfulness of my statements in evaluating my potential as an independent contractor physician for locum tenens assignments or potential for referral for a permanent position. I further acknowledge that the decision to offer me as a candidate is solely at the discretion of Independence Anesthesia Services, any information received from references or other agencies by Independence Anesthesia Services may not be released to me without the consent of the reference or agency, and I agree that I will not enter into an arrangement to provide temporary or permanent physician services with any individual, group, or institution to whom I am referred by Independence Anesthesia Services except through Independence Anesthesia Services with the written consent of Independence Anesthesia Services.

Applicant's Signature: _____

Printed Name: _____ Date: _____

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Authorization for Release of Information

In order to assist in my obtaining of credentials, certifications, or licensure, I authorize the release to Independence Anesthesia Services or representatives of Independence Anesthesia Services presenting this document of any and all information, records, documents, or copies thereof, which may assist in the evaluation of my qualifications, character, education, training, and competence, including, but not limited to, records and reports of the following: education, teaching appointments, hospital associations, malpractice insurance coverage, certifications, state licensure, experience (past and present), employment, professional associations, continuing education requirements, peer reviews, disciplinary proceedings, and reductions or limitations of functions.

I release from any liability and from any restrictions as to confidentiality or privacy all hospitals, schools, physicians, employers, individuals, agencies, or organizations that provide information about me at the request of the agency submitting this authorization.

_____

Provider Signature

_____

Provider Print

_____

Date