

(Please Type or Print)

Section I-Individual Information

TYPE OF PROFESSIONAL _____

LAST NAME FIRST MIDDLE (JR., SR., ETC.)

MAIDEN NAME YEARS ASSOCIATED (YYYY-YYYY) OTHER NAME YEARS ASSOCIATED (YYYY-YYYY)

HOME MAILING ADDRESS _____

CITY STATE/COUNTRY POSTAL CODE

HOME PHONE NUMBER SOCIAL SECURITY NUMBER Female Male

CORRESPONDENCE ADDRESS _____

CITY STATE/COUNTRY POSTAL CODE

PHONE NUMBER FAX NUMBER E-MAIL

DATE OF BIRTH (MM/DD/YYYY) PLACE OF BIRTH CITIZENSHIP

IF NOT AMERICAN CITIZEN, VISA NUMBER & STATUS ARE YOU ELIGIBLE TO WORK IN THE UNITED STATES?
 Yes No

U.S. MILITARY SERVICE/PUBLIC HEALTH DATES OF SERVICE (MM/DD/YYYY) TO (MM/DD/YYYY) LAST LOCATION
 Yes No

BRANCH OF SERVICE ARE YOU CURRENTLY ON ACTIVE OR RESERVE MILITARY DUTY?
 Yes No

Education

MEDICAL / DENTAL / OSTEOPATHIC SCHOOL DEGREE ATTAINED

CITY STATE/COUNTRY POSTAL CODE ATTENDANCE DATES (MM/YYYY TO MM/YYYY) PROGRAM COMPLETED
 Yes No

Post-Graduate Education

Internship Residency Fellowship Teaching Appointment
INSTITUTION CHAIRMAN SPECIALTY/TYPE OF PROGRAM

CITY STATE/COUNTRY POSTAL CODE ATTENDANCE DATES (MM/YYYY TO MM/YYYY) PROGRAM COMPLETED
 Yes No

Internship Residency Fellowship Teaching Appointment
INSTITUTION CHAIRMAN SPECIALTY/TYPE OF PROGRAM

CITY STATE/COUNTRY POSTAL CODE ATTENDANCE DATES (MM/YYYY TO MM/YYYY) PROGRAM COMPLETED
 Yes No

Internship Residency Fellowship Teaching Appointment
INSTITUTION CHAIRMAN SPECIALTY/TYPE OF PROGRAM

CITY STATE/COUNTRY POSTAL CODE ATTENDANCE DATES (MM/YYYY TO MM/YYYY) PROGRAM COMPLETED
 Yes No

Internship Residency Fellowship Teaching Appointment
INSTITUTION CHAIRMAN SPECIALTY/TYPE OF PROGRAM

CITY STATE/COUNTRY POSTAL CODE ATTENDANCE DATES (MM/YYYY TO MM/YYYY) PROGRAM COMPLETED
 Yes No

Licenses and Certificates- Please include all license(s) and certifications in all states where you are currently or have previously been licensed.

STATE OF REGISTRATION	LICENSE / CERTIFICATION NUMBER	STATUS
STATE OF REGISTRATION	LICENSE / CERTIFICATION NUMBER	STATUS
STATE OF REGISTRATION	LICENSE / CERTIFICATION NUMBER	STATUS
STATE OF REGISTRATION	LICENSE / CERTIFICATION NUMBER	STATUS
STATE OF REGISTRATION	LICENSE / CERTIFICATION NUMBER	STATUS
<input type="checkbox"/> DEA Number	ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)
<input type="checkbox"/> State CS Number	ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)
UPIN		NATIONAL PROVIDER IDENTIFIER (WHEN AVAILABLE)
ARE YOU A PARTICIPATING MEDICARE PROVIDER? <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare Provider Number:		ARE YOU A PARTICIPATING MEDICAID PROVIDER? <input type="checkbox"/> Yes <input type="checkbox"/> No Medicaid Provider Number:
EDUCATIONAL COUNCIL FOR FOREIGN MEDICAL GRADUATES (ECFMG) <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No ECFMG Number:		ECFMG ISSUE DATE (MM/DD/YYYY)

Professional/Specialty Information

PRIMARY SPECIALTY	BOARD CERTIFIED? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Certifying Board:	
INITIAL CERTIFICATION DATE (MM/YYYY)	RECERTIFICATION DATE(S), IF APPLICABLE (MM/YYYY)	EXPIRATION DATE, IF APPLICABLE (MM/YYYY)
IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY. <input type="checkbox"/> I AM NOT BOARD ELIGIBLE		
<input type="checkbox"/> I have taken exam, results pending for Board.		
<input type="checkbox"/> I have taken Part I and am eligible for Part II of the Exam.		
<input type="checkbox"/> I am intending to sit for the Boards on (date)		
<input type="checkbox"/> I am not planning to take Boards.		
If not certified, number of times Boards attempted and failed.		
SECONDARY SPECIALTY	BOARD CERTIFIED? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Certifying Board:	
INITIAL CERTIFICATION DATE (MM/YYYY)	RECERTIFICATION DATE(S), IF APPLICABLE (MM/YYYY)	EXPIRATION DATE, IF APPLICABLE (MM/YYYY)

Exams and Certifications

CHECK ALL THAT APPLY

<input type="checkbox"/> ACLS	EXPIRATION DATE	<input type="checkbox"/> BLS	EXPIRATION DATE	<input type="checkbox"/> ATLS	EXPIRATION DATE	<input type="checkbox"/> PALS	EXPIRATION DATE
<input type="checkbox"/> FLEX	YEAR:	#ATTEMPTS	:	<input type="checkbox"/> USMLE	STEP 1: YEAR:	#ATTEMPTS	:
<input type="checkbox"/> NATIONAL BOARDS	YEAR:	#ATTEMPTS:	:		STEP 2: YEAR:	#ATTEMPTS	:
<input type="checkbox"/> ECFMG	YEAR:	#ATTEMPTS:	:		STEP 3: YEAR:	#ATTEMPTS	:

Hospital Affiliations-Please include all hospitals where you currently have or have previously had **privileges**.

HOSPITAL / FACILITY	CITY / STATE / ZIP	
TYPE OF PRIVILEGES/STAFF STATUS	AFFILIATION DATES (MM/YYYY TO MM/YYYY)	FULL UNRESTRICTED PRIVILEGES? <input type="checkbox"/> Yes <input type="checkbox"/> No
HOSPITAL / FACILITY	CITY / STATE / ZIP	
TYPE OF PRIVILEGES/STAFF STATUS	AFFILIATION DATES (MM/YYYY TO MM/YYYY)	FULL UNRESTRICTED PRIVILEGES? <input type="checkbox"/> Yes <input type="checkbox"/> No
HOSPITAL / FACILITY	CITY / STATE / ZIP	
TYPE OF PRIVILEGES/STAFF STATUS	AFFILIATION DATES (MM/YYYY TO MM/YYYY)	FULL UNRESTRICTED PRIVILEGES? <input type="checkbox"/> Yes <input type="checkbox"/> No
HOSPITAL / FACILITY	CITY / STATE / ZIP	
TYPE OF PRIVILEGES/STAFF STATUS	AFFILIATION DATES (MM/YYYY TO MM/YYYY)	FULL UNRESTRICTED PRIVILEGES? <input type="checkbox"/> Yes <input type="checkbox"/> No
HOSPITAL / FACILITY	CITY / STATE / ZIP	
TYPE OF PRIVILEGES/STAFF STATUS	AFFILIATION DATES (MM/YYYY TO MM/YYYY)	FULL UNRESTRICTED PRIVILEGES? <input type="checkbox"/> Yes <input type="checkbox"/> No

References—Please provide four peer references from the same field and/or specialty who are not partners in your own group practice and are not relatives. All peer references should have firsthand knowledge of your abilities.

1 NAME/TITLE		PHONE NUMBER
ADDRESS		CITY / STATE / ZIP
INSTITUTION	EMAIL	FAX
2 NAME/TITLE		PHONE NUMBER
ADDRESS		CITY / STATE / ZIP
INSTITUTION	EMAIL	FAX
3 NAME/TITLE		PHONE NUMBER
ADDRESS		CITY / STATE / ZIP
INSTITUTION	EMAIL	FAX
4 NAME/TITLE		PHONE NUMBER
ADDRESS		CITY / STATE / ZIP
INSTITUTION	EMAIL	FAX

Locum tenens experience - Please list all organizations / locations where you have provided locum tenens coverage within the last five years.

FACILITY / PRACTICE NAME	SUPERVISOR	CITY	STATE	DATES (MM/YYYY TO MM/YYYY)
FACILITY / PRACTICE NAME	SUPERVISOR	CITY	STATE	DATES (MM/YYYY TO MM/YYYY)
FACILITY / PRACTICE NAME	SUPERVISOR	CITY	STATE	DATES (MM/YYYY TO MM/YYYY)
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FACILITY / PRACTICE NAME	SUPERVISOR	CITY	STATE	DATES (MM/YYYY TO MM/YYYY)
FACILITY / PRACTICE NAME	SUPERVISOR	CITY	STATE	DATES (MM/YYYY TO MM/YYYY)

Disclosure Questions - Please provide an explanation for any question answered "Yes" on the page (Disclosure Questions-continued) following the disclosure questions.

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 State Controlled Substance

- 10) Have your Federal DEA and/or STATE 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

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 (pending, settled, arbitrated, mediated or litigated)? Yes No

Criminal

17) Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony? Yes No

18) Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony, involving 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

20) Are you currently abusing alcohol, using any illegal drugs, or failing to take legally prescribed drugs in the manner prescribed? Yes No

21) Have you abused alcohol, used illegal drugs, or failed to take legally prescribed drugs in the manner prescribed in the past? If yes what drugs, and how recently have you used these illegal drugs? Yes No

22) 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

23) Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients? Yes No

24) 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 following page to explain “Yes” answers to any question, except question 16. For question 16, use attachment “A” for explanations.

STANDARD AUTHORIZATION, ATTESTATION AND RELEASE

I understand and agree that, as part of the credentialing application process for consideration of placement as a locum tenens or permanent direct hire employee (hereinafter, referred to as "Participation") at, with or through:

Camden Healthcare Staffing
Camden Healthcare Government Staffing
Camden Healthcare Community Staffing
AJ Riggins Health Search

(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. In consideration of my Participation the information obtained relating to the application process will be shared with clients of the Entity at which I am being considered.

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 a position or contract, of any type, 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.

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 Clients at which I am being considered, 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 that any Entity, any Agent(s), or any other party involved in the credentialing/application process is entitled to absolute immunity from suit. I agree not to sue any 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 in writing, and must be dated and signed by me. 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 _____ DATE _____

NAME (PLEASE PRINT OR TYPE) _____

Attachment A – Malpractice Claims History

INCIDENT DATE (MM/DD/YYYY)	DATE CLAIM WAS FILED (MM/DD/YYYY)	CLAIM/CASE STATUS
PROFESSIONAL LIABILITY CARRIER INVOLVED		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	POLICY NUMBER	AMOUNT OF AWARD OR SETTLEMENT & AMOUNT PAID \$ \$
METHOD OF RESOLUTION <input type="checkbox"/> Dismissed	<input type="checkbox"/> Settled (with prejudice)	<input type="checkbox"/> Settled (without prejudice)
<input type="checkbox"/> Judgment for Defendant(s)	<input type="checkbox"/> Judgment for Plaintiff(s)	<input type="checkbox"/> Mediation or Arbitration
DESCRIPTION OF ALLEGATIONS		
WERE YOU PRIMARY DEFENDANT OR CO-DEFENDANT?	NUMBER OF OTHER CO-DEFENDANTS	YOUR INVOLVEMENT (ATTENDING, CONSULTING, ETC.)
DESCRIPTION OF ALLEGED INJURY TO THE PATIENT		
TO THE BEST OF YOUR KNOWLEDGE, IS THIS CASE INCLUDED IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
INCIDENT DATE (MM/DD/YYYY)	DATE CLAIM WAS FILED (MM/DD/YYYY)	CLAIM/CASE STATUS
PROFESSIONAL LIABILITY CARRIER INVOLVED		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	POLICY NUMBER	AMOUNT OF AWARD OR SETTLEMENT & AMOUNT PAID PAID \$ \$
METHOD OF RESOLUTION <input type="checkbox"/> Dismissed	<input type="checkbox"/> Settled (with prejudice)	<input type="checkbox"/> Settled (without prejudice)
<input type="checkbox"/> Judgment for Defendant(s)	<input type="checkbox"/> Judgment for Plaintiff(s)	<input type="checkbox"/> Mediation or Arbitration
DESCRIPTION OF ALLEGATIONS		
WERE YOU PRIMARY DEFENDANT OR CO-DEFENDANT?	NUMBER OF OTHER CO-DEFENDANTS	YOUR INVOLVEMENT (ATTENDING, CONSULTING, ETC.)
DESCRIPTION OF ALLEGED INJURY TO THE PATIENT		
TO THE BEST OF YOUR KNOWLEDGE, IS THIS CASE INCLUDED IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)? <input type="checkbox"/> Yes <input type="checkbox"/> No		



INDEPENDENT CONTRACTOR DECLARATION

The undersigned service provider (the "Provider") declares, acknowledges and agrees that he/she is an independent contractor and is not an employee of Camden Healthcare Staffing, LLC or any of its affiliates.

1. I am a trained medical or dental practitioner engaged in the practice of medicine or dentistry.
2. I am solely responsible for my professional actions in providing dentistry services to patients at the contracted healthcare facilities or elsewhere.
3. Camden Healthcare Staffing, LLC does not have the right to direct or control the manner in which I practice my profession.
4. I independently determine the assignments I am willing to accept and the rate at which I will be paid for each assignment. I cannot be directed by Camden Healthcare Staffing, LLC to accept assignments.
5. Camden Healthcare Staffing, LLC does not direct my professional services in any manner, including the time, place, type of professional service, working conditions, quality of the professional service, my right to utilize or hire assistants, or the prices charged for the services I render.
6. I have the right to terminate my relationship with Camden Healthcare Staffing, LLC at any time, and I may terminate an assignment with or without cause by giving the agreed written notice.
7. To my knowledge, Camden Healthcare Staffing, LLC has no relationship with the healthcare facilities with whom I accept assignments other than that of a placement agency, and I understand that Camden Healthcare Staffing, LLC is not licensed to nor is it engaged in the practice of medicine or dentistry.
8. I am not employed by Camden Healthcare Staffing, LLC. As an independent contractor, I agree that I am responsible for and will pay all federal, state and local income or self-employment taxes due on payments received as a result of this assignment, and I am **NOT** entitled to claim unemployment benefits or workers compensation benefits against Camden Healthcare Staffing, LLC.
9. To the extent I receive payments from Camden Healthcare Staffing, LLC in relation to an assignment, such payments are made by Camden Healthcare Staffing, LLC on behalf of the Client.

This Declaration is a true and correct statement of the facts set forth herein.

This Declaration is executed effective as of _____, 2009.

MEDICAL OR DENTAL / PROVIDER

CAMDEN HEALTHCARE STAFFING, LLC

(Signature)

(Signature)

(Print Name)

(Print Name)



Date of Birth Form

I understand it is necessary for me to disclose my date of birth in order for Camden Healthcare Staffing's Assurance Department to verify my credentials.

Date of Birth

Provider's Signature

Provider's printed name

Upon receipt, this document will be separated from the application packet, placed in your file, and will not be considered when making assignment decisions.

ALL QUALIFIED APPLICANTS RECEIVE CONSIDERATION WITHOUT REGARD TO RACE, COLOR, RELIGION, SEX, AGE, NATIONAL ORIGIN, DISABILITY, MARITAL STATUS, VETERAN STATUS OR ANY OTHER LEGALLY PROTECTED STATUS.