



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 _____, 20____, between _____, d/b/a _____ (hereinafter called "the Contractor"), 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: _____



Physician Application

If the answer to any question is "yes", please provide a detailed explanation and necessary documentation.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have any disciplinary actions been initiated or are any pending against you by any state licensure board, institution, professional society, or healthcare facility?
<input type="checkbox"/> Yes <input type="checkbox"/> 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?
<input type="checkbox"/> Yes <input type="checkbox"/> 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)?
<input type="checkbox"/> Yes <input type="checkbox"/> 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)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been named as a defendant in any criminal proceeding?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has your professional liability coverage ever been terminated by action of the insurance company? If yes, state when and by what company.
<input type="checkbox"/> Yes <input type="checkbox"/> 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.
<input type="checkbox"/> Yes <input type="checkbox"/> 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.
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have any professional liability suits been filed against you?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have any professional liability suits been filed against you which are presently pending?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have any judgments or settlements been made against you in professional liability cases?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been hospitalized any time during the past five years?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently under the care of a physician or psychologist?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been denied health, life, or disability insurance?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any limitations on your health, life, or disability insurance?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you currently or have you ever had any problems with alcohol or drug dependency?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you presently use any illegal drugs?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently taking any medication that may affect your clinical judgment or motor skills?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently under any limitations concerning your activities or workload?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you presently have any physical, mental, or emotional condition which might affect your ability to perform the clinical privileges you are requesting?

Independent Contractor Sign: _____

Date: _____

Independent Contractor Print: _____



Physician Application

Personal Information					
Last Name	First Name	Middle Name	Suffix	Degree	
Previous Names	Date of Birth	Address			
City, State, Zip Code	Birth City	Birth State	NPI Number		
Home Phone	Cell Phone	Office Phone			
Home Fax	Office Fax	Email Address			
Board Specialty					
Specialty Board	Board Certified <input type="checkbox"/>	Board Eligible <input type="checkbox"/>	Date Certified	Certificate Number	Recert Date
Specialty Board	Board Certified <input type="checkbox"/>	Board Eligible <input type="checkbox"/>	Date Certified	Certificate Number	Recert Date

LICENSURE

Current States _____

Desired States _____

(we will gladly help with licensure)

	Yes	No	<u>Comments</u>
OB	<input type="checkbox"/>	<input type="checkbox"/>	_____
ENT	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ortho	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urology	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gyn	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vascular	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neuro (Heads)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neuro (Backs)	<input type="checkbox"/>	<input type="checkbox"/>	_____

	Yes	No	<u>Comments</u>
Epidurals	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spinals	<input type="checkbox"/>	<input type="checkbox"/>	_____
Regionals	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blocks	<input type="checkbox"/>	<input type="checkbox"/>	_____
Plastics	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pediatric	<input type="checkbox"/>	<input type="checkbox"/>	_____
Transplants	<input type="checkbox"/>	<input type="checkbox"/>	_____
Trauma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bariatric	<input type="checkbox"/>	<input type="checkbox"/>	_____

PREFERRED ASSIGNMENT TYPES

Directed / Team / Solo _____

Short/Long/ Perm. _____

Shift Times: _____

Call Y/N _____

Weekends Y/N _____

Hospital Size _____

Region(s) of US _____

Metro/Rural _____

Lodging Requests _____

Travel Requests _____

Prof. Liability Ins. Y/N _____

Coverage Limits _____