LAKES URGENT CARE
When your health concerns can't wait.

APPLICATION PACKET CHECKLIST

- ☐ Employee Information Sheet
- ☐ HIPAA Confidentiality Pledge Form
- ☐ Authorization for Direct Deposit
- ☐ Form I-9, Employment Eligibility Verification
- ☐ Federal W-4 Form
- ☐ MI W-4Form
- ☐ Professional Liability Insurance Express Application – For Health Care Professionals (Physicians & Surgeons)
  - Fill out to the best of your ability
  - #11 – Don't forget to fill out Home Address and Phone #
- ☐ The Doctors Company form
- ☐ GME Moonlighting Request Form – **BOTSFORD RESIDENTS ONLY**
- ☐ Letter of Recommendation from Program Director on Hospital Letter Head stating that resident is in good standing and is **specifically** allowed to begin working with Lakes Urgent Care
- ☐ Declaration Page and "loss run sheet" from **any other previous or current institutions that you have moonlighted with.**
- ☐ Copy of Michigan Physician License and Pharmacy License
- ☐ Copy of DEA Certificate
- ☐ Copy of CV/Resume
- ☐ Copy of either your Passport **OR** Combination of Driver's License and Social Security Card

Please complete and send Application Packet in its entirety to:

Mail:		**Fax:**
Lakes Urgent Care	**OR**	248-926-9112
2300 Haggerty Road, Suite 1010		Attn: Lakes Urgent Care
West Bloomfield, MI 48323		

LAKES URGENT CARE

When your health concerns can't wait.

Employee Information Sheet

Name: _____

Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Cell / Home

Email: _____

Date of Birth: _____

Social Security Number: _____

Driver License Number _____

Marital Status: Single Married Sex: M F

**********Completed by Adminstration**********

Hire Date: _____ Pay Rate: _____

Job Title: Provider ▪ Mid-Level ▪ Clinical (MA or MT) ▪ Clerical

Notes:

Checklist Complete _____

Date Completed: _____

Pay Systems _____

Master Spreadsheet _____

Easy Clocking Access _____

Paystub Access _____

Lakes Medical Center
2300 Haggerty Road Suite 1010
West Bloomfield, MI 48323
248/926-0900 * (Fax) 248/926-8112

PROTECTED HEALTH INFORMATION
PLEDGE OF CONFIDENTIALITY

I have read and understand Lakes Urgent Care's policies and procedures regarding the privacy and security of its patients' protected health information ("PHI"), which is designed to ensure that Lakes Urgent Care complies with all the applicable rules and regulations regarding the confidential treatment of Lakes Urgent Care's patients' information.

In consideration of my employment or association with Lakes Urgent Care and as an integral part of the terms and conditions of my employment or association with Lakes Urgent Care., I hereby agree, pledge and undertake that I will not at any time, during my employment or association with Lakes Urgent Care or after my employment or association ends, access or use PHI, or reveal or disclose to any persons within or outside of Lakes Urgent Care any PHI except as may be required in the course of my duties and responsibilities and in accordance with applicable laws and/or policies of Lakes Urgent Care, governing the proper release of information.

I further understand that my obligations outlined above will continue after my employment/contract/association/appointment with Lakes Urgent Care ends.

I further understand that my obligations concerning the protection of the confidentiality of PHI relate to all PHI whether I acquired the information through my employment/contract /association/appointment with Lakes Urgent Care.

I also understand that the unauthorized use or disclosure of a patients' PHI will result in disciplinary action up to and including termination of my employment/contract/ association/appointment the imposition of fines pursuant to state and federal laws, and a report to my professional regulatory body.

Signed by:

_____
(Signature)

_____
(Print Name)

_____
(Date)

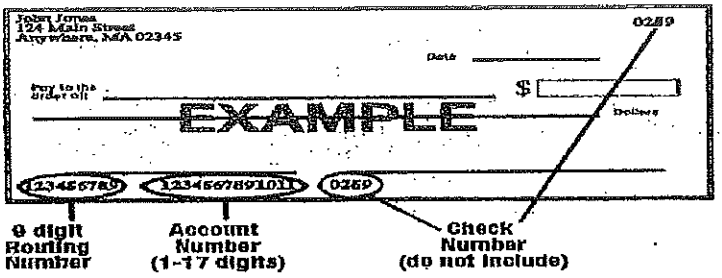
Direct Deposit Authorization Form

Please print and complete ALL the information below.

Name: _____

Address: _____

City, State, Zip: _____



Name of Bank: _____

Account #: _____

9-Digit Routing #: _____

Amount: ☐ $ _____ ☐ _____% or ☐ Entire Paycheck

Type of Account: Checking Savings (Circle One)

Name of Bank: _____

Account #: _____

9-Digit Routing #: _____

Amount: ☐ $ _____ ☐ _____% or ☐ Entire Paycheck

Type of Account: Checking Savings (Circle One)

Please attach a voided check for <u>each</u> bank account to which funds should be deposited.

Lakes Urgent Care, is hereby authorized to direct deposit my pay to the account(s) listed above. This authorization will remain in effect until I modify or cancel it in writing.

Employee Signature: _____

Date: _____

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

▶ **START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐-☐☐-☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			B. Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2023

Step 1: Enter Personal Information

(a) First name and middle initial | Last name | (b) Social security number

Address

City or town, state, and ZIP code

Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov.

(c) ☐ Single or Married filing separately
☐ Married filing jointly or Qualifying surviving spouse
☐ Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, other details, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Reserved for future use.

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

TIP: If you have self-employment income, see page 2.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $

Multiply the number of other dependents by $500 . . . . . $

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2023 if you meet both of the following conditions: you had no federal income tax liability in 2022 **and** you expect to have no federal income tax liability in 2023. You had no federal income tax liability in 2022 if (1) your total tax on line 24 on your 2022 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2023 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2024.

Your privacy. If you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c).

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay income and self-employment taxes through withholding from your wages, you should enter the self-employment income on Step 4(a). Then compute your self-employment tax, divide that tax by the number of pay periods remaining in the year, and include that resulting amount per pay period on Step 4(c). You can also add half of the annual amount of self-employment tax to Step 4(b) as a deduction. To calculate self-employment tax, you generally multiply the self-employment income by 14.13% (this rate is a quick way to figure your self-employment tax and equals the sum of the 12.4% social security tax and the 2.9% Medicare tax multiplied by 0.9235). See Pub. 505 for more information, especially if the sum of self-employment income multiplied by 0.9235 and wages exceeds $160,200 for a given individual.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

If you (and your spouse) have a total of only two jobs, you may check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

CAUTION ***Multiple jobs.*** *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2023 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** $ _____

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** $ _____

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . **2b** $ _____

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . **2c** $ _____

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. . . . . **3** _____

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . **4** $ _____

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2023 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $ _____

2 Enter:
- $27,700 if you're married filing jointly or a qualifying surviving spouse
- $20,800 if you're head of household
- $13,850 if you're single or married filing separately

. . . . . **2** $ _____

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . **3** $ _____

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . **4** $ _____

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . **5** $ _____

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$850	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,870
$10,000 - 19,999	0	930	1,850	2,000	2,200	2,220	2,220	2,220	2,220	2,220	3,200	4,070
$20,000 - 29,999	850	1,850	2,920	3,120	3,320	3,340	3,340	3,340	3,340	4,320	5,320	6,190
$30,000 - 39,999	850	2,000	3,120	3,320	3,520	3,540	3,540	3,540	4,520	5,520	6,520	7,390
$40,000 - 49,999	1,000	2,200	3,320	3,520	3,720	3,740	3,740	4,720	5,720	6,720	7,720	8,590
$50,000 - 59,999	1,020	2,220	3,340	3,540	3,740	3,760	4,750	5,750	6,750	7,750	8,750	9,610
$60,000 - 69,999	1,020	2,220	3,340	3,540	3,740	4,750	5,750	6,750	7,750	8,750	9,750	10,610
$70,000 - 79,999	1,020	2,220	3,340	3,540	4,720	5,750	6,750	7,750	8,750	9,750	10,750	11,610
$80,000 - 99,999	1,020	2,220	4,170	5,370	6,570	7,600	8,600	9,600	10,600	11,600	12,600	13,460
$100,000 - 149,999	1,870	4,070	6,190	7,390	8,590	9,610	10,610	11,660	12,860	14,060	15,260	16,330
$150,000 - 239,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$240,000 - 259,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$260,000 - 279,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	18,140
$280,000 - 299,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,870	17,870	19,740
$300,000 - 319,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,470	15,470	17,470	19,470	21,340
$320,000 - 364,999	2,040	4,440	6,760	8,550	10,750	12,770	14,770	16,770	18,770	20,770	22,770	24,640
$365,000 - 524,999	2,970	6,470	9,890	12,390	14,890	17,220	19,520	21,820	24,120	26,420	28,720	30,880
$525,000 and over	3,140	6,840	10,460	13,160	15,860	18,390	20,890	23,390	25,890	28,390	30,890	33,250

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$310	$890	$1,020	$1,020	$1,020	$1,860	$1,870	$1,870	$1,870	$1,870	$2,030	$2,040
$10,000 - 19,999	890	1,630	1,750	1,750	2,600	3,600	3,600	3,600	3,600	3,760	3,960	3,970
$20,000 - 29,999	1,020	1,750	1,880	2,720	3,720	4,720	4,730	4,730	4,890	5,090	5,290	5,300
$30,000 - 39,999	1,020	1,750	2,720	3,720	4,720	5,720	5,730	5,890	6,090	6,290	6,490	6,500
$40,000 - 59,999	1,710	3,450	4,570	5,570	6,570	7,700	7,910	8,110	8,310	8,510	8,710	8,720
$60,000 - 79,999	1,870	3,600	4,730	5,860	7,060	8,260	8,460	8,660	8,860	9,060	9,260	9,280
$80,000 - 99,999	1,870	3,730	5,060	6,260	7,460	8,660	8,860	9,060	9,260	9,460	10,430	11,240
$100,000 - 124,999	2,040	3,970	5,300	6,500	7,700	8,900	9,110	9,610	10,610	11,610	12,610	13,430
$125,000 - 149,999	2,040	3,970	5,300	6,500	7,700	9,610	10,610	11,610	12,610	13,610	14,900	16,020
$150,000 - 174,999	2,040	3,970	5,610	7,610	9,610	11,610	12,610	13,750	15,050	16,350	17,650	18,770
$175,000 - 199,999	2,720	5,450	7,580	9,580	11,580	13,870	15,180	16,480	17,780	19,080	20,380	21,490
$200,000 - 249,999	2,900	5,930	8,360	10,660	12,960	15,260	16,570	17,870	19,170	20,470	21,770	22,880
$250,000 - 399,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$400,000 - 449,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$450,000 and over	3,140	6,380	9,010	11,510	14,010	16,510	18,010	19,510	21,010	22,510	24,010	25,330

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$620	$860	$1,020	$1,020	$1,020	$1,020	$1,650	$1,870	$1,870	$1,890	$2,040
$10,000 - 19,999	620	1,630	2,060	2,220	2,220	2,220	2,850	3,850	4,070	4,090	4,290	4,440
$20,000 - 29,999	860	2,060	2,490	2,650	2,650	3,280	4,280	5,280	5,520	5,720	5,920	6,070
$30,000 - 39,999	1,020	2,220	2,650	2,810	3,440	4,440	5,440	6,460	6,880	7,080	7,280	7,430
$40,000 - 59,999	1,020	2,220	3,130	4,290	5,290	6,290	7,480	8,680	9,100	9,300	9,500	9,650
$60,000 - 79,999	1,500	3,700	5,130	6,290	7,480	8,680	9,880	11,080	11,500	11,700	11,900	12,050
$80,000 - 99,999	1,870	4,070	5,690	7,050	8,250	9,450	10,650	11,850	12,260	12,460	12,870	13,820
$100,000 - 124,999	2,040	4,440	6,070	7,430	8,630	9,830	11,030	12,230	13,190	14,190	15,190	16,150
$125,000 - 149,999	2,040	4,440	6,070	7,430	8,630	9,980	11,980	13,980	15,190	16,190	17,270	18,530
$150,000 - 174,999	2,040	4,440	6,070	7,980	9,980	11,980	13,980	15,980	17,420	18,720	20,020	21,280
$175,000 - 199,999	2,190	5,390	7,820	9,980	11,980	14,060	16,360	18,660	20,170	21,470	22,770	24,030
$200,000 - 249,999	2,720	6,190	8,920	11,380	13,680	15,980	18,280	20,580	22,090	23,390	24,690	25,950
$250,000 - 449,999	2,970	6,470	9,200	11,660	13,960	16,260	18,560	20,860	22,380	23,680	24,980	26,230
$450,000 and over	3,140	6,840	9,770	12,430	14,930	17,430	19,930	22,430	24,150	25,650	27,150	28,600

MI-W4

(Rev. 12-20)

EMPLOYEE'S MICHIGAN WITHHOLDING EXEMPTION CERTIFICATE
STATE OF MICHIGAN - DEPARTMENT OF TREASURY

This certificate is for Michigan income tax withholding purposes only. ***Read instructions on page 2 before completing this form.***

Issued under P.A. 281 of 1967.

		▶ 1. Full Social Security Number	▶ 2. Date of Birth
▶ 3. Name (First, Middle Initial, Last)		4. Driver's License Number or State ID	
Home Address (No., Street, P.O. Box or Rural Route)		▶ 5. Are you a new employee? ☐ Yes If Yes, enter date of hire..... ☐ No	(mm/dd/yyyy)
City or Town	State	ZIP Code	

6. Enter the number of personal and dependent exemptions (see instructions) ..... ▶ 6.

7. Additional amount you want deducted from each pay (if employer agrees) .....7. $ .00

8. I claim exemption from withholding because (see instructions):

a. ☐ A Michigan income tax liability is not expected this year.

b. ☐ Wages are exempt from withholding. Explain: _____

c. ☐ Permanent home (domicile) is located in the following Renaissance Zone: _____

EMPLOYEE: If you fail or refuse to file this form, your employer must withhold Michigan income tax from your wages without allowance for any exemptions. Keep a copy of this form for your records. See additional instructions on page 2.

Under penalty of perjury, I certify that the number of withholding exemptions claimed on this certificate does not exceed the number I am allowed to claim. If claiming exemption from withholding, I certify that I do not anticipate a Michigan income tax liability this year.

9. Employee's Signature	▶ Date

EMPLOYER: Complete the below section.

10. Employer's Name	▶ 11. Federal Employer Identification Number		
Address (No., Street, P.O. Box or Rural Route)	City or Town	State	ZIP Code
Name of Contact Person	Contact Phone Number		

INSTRUCTIONS TO EMPLOYER: Keep a copy of this certificate with your records. All new hires must be reported to the State of Michigan. See **www.mi-newhire.com** for information.

In addition, a copy of this form must be sent to the Michigan Department of Treasury if the employee claims 10 or more exemptions or claims they are exempt from withholding. Send a copy to:

Michigan Department of Treasury
Tax Technical Section
P.O. Box 30477
Lansing, MI 48909

INSTRUCTIONS TO *EMPLOYEE'S MICHIGAN WITHHOLDING EXEMPTION CERTIFICATE* (Form MI-W4)

You must submit a Michigan withholding exemption certificate (form MI-W4) to your employer on or before the date that employment begins. If you fail or refuse to submit this certificate, your employer must withhold tax from your compensation without allowance for any exemptions. Your employer is required to notify the Michigan Department of Treasury if you have claimed 10 or more personal or dependency exemptions or claimed that you are exempt from withholding.

You MUST provide a new MI-W4 to your employer within 10 days if your residency status changes or if your exemptions decrease because: a) your spouse, for whom you have been claiming an exemption, is divorced or legally separated from you or claims his/her own exemption(s) on a separate certificate, or b) a dependent no longer qualifies under the Internal Revenue Code.

Line 5: If you check "Yes," enter your date of hire.

Line 6: Personal and dependency exemptions. The number of exemptions claimed here may not exceed the number of exemptions you are entitled to claim on a *Michigan Individual Income Tax Return* (Form MI-1040). Dependents include qualifying children and qualifying relatives under the Internal Revenue Code, even if your AGI exceeds the limits to claim federal tax credits for them.

Do not claim the same exemptions more than once or tax will be under-withheld. Specifically, **do not claim:**

- Your personal exemption if someone else will claim you as their dependent.
- Your personal exemption with more than one employer at a time.
- Your spouse's personal exemption if they claim it with their employer.
- Your dependency exemptions if someone else (for example, your spouse) is claiming them with their employer.

Line 7: You may designate additional withholding if you expect to owe more than the amount withheld.

Line 8a: You may claim exemption from Michigan income tax withholding if all of the following conditions are met:

i) Your employment is intermittent, temporary, or less than full time;

ii) Your personal and dependency exemptions exceed your annual taxable compensation;

iii) You claimed exemption from federal withholding; and

iv) You did not incur a Michigan income tax liability for the previous year.

Line 8b: Reasons wages might be exempt from withholding include:

- You are a nonresident spouse of military personnel stationed in Michigan.
- You are a resident of one of the following reciprocal states while working in Michigan: Illinois, Indiana, Kentucky, Minnesota, Ohio, or Wisconsin.
- You are a member of a Native American tribe that has a tax agreement with the State of Michigan and whose principal place of residence is within the designated agreement area.
- You are an enrolled member of a federally-recognized tribe that does not have a tax agreement with the State of Michigan, you reside within that tribe's Indian Country (as defined in 18 USC 1151), and compensation from this job will be earned within that Indian Country.

Line 8c: For questions about Renaissance Zones, contact your local assessor's office.

THEDOCTORSCOMPANY

PROFESSIONAL LIABILITY INSURANCE EXPRESS APPLICATION

For Healthcare Professionals
(Physicians and Surgeons)

AGENT INFORMATION

Agent name:

Address 1:

Address 2:

City: State: Zip:

Phone: Fax:

E-mail:

Website:

185 Greenwood Road Napa, CA 94558 (800) 421-2368 Fax: (707) 226-0107 E-mail: sales@thedoctors.com www.thedoctors.com

APPLICATION INSTRUCTIONS AND CHECKLIST

Prior to completing the attached application, please read and follow these instructions. Please verify that all required attachments are included so that we may process your application promptly and efficiently.

- Please complete this form electronically or print your responses legibly.
- Please sign and date the application where indicated.
- All information requested must be fully and accurately completed.
- If changes or corrections must be made to the completed application, strike out or line through the incorrect information, write in the modification, and initial and date the change.
- If a particular question does not apply to you, please write "N/A."
- The Medical Procedures questionnaire must be completed. If the procedures you perform are not mentioned in the questionnaire, please list them in the Remarks section.
- If you wish to explain any of your answers, please use the Remarks section. If you need additional space, please continue your answers on a separate page and attach it to the application.
- Claims information should be provided for a six-year experience period. This applies to open and closed claims and to any incidents reported to a previous carrier. It is important that you provide complete and detailed claims information, including current company loss runs.

Required Attachments

Please include a current copy of the following documents with the application:

- ☐ Your curriculum vitae (CV)
- ☐ Your Declarations Page from your current policy, showing your policy period, limits of liability, retroactive date, and any exclusions that were applied to your policy
- ☐ Your loss runs from all insurance carriers that insured you for the past six years (if applicable)
- ☐ Your current letterhead and advertisements, including online marketing used in the last year and a copy of the homepage of your website (if applicable)

Insurance coverage is subject to underwriting approval and payment of the premium. No coverage exists until the premium is received and a binder or coverage summary, together with any endorsements that may apply, has been issued to the first named insured.

Except to the extent as may otherwise be provided in the policy and its endorsements, the coverage of a claims-made policy is limited generally to liability for only those claims that are first reported in writing to the Company while the policy is inforce.

Claims-made vs. Occurrence: Claims-made policies generally cover incidents and events that both happen and are reported to us while you have a policy with The Doctors Company. You may request a retroactive date to allow you to report to us claims that arise out of incidents that took place previously while you were insured elsewhere. You can also purchase extended reporting, or tail, coverage which will allow you to report claims that arise out of incidents occurring after your retroactive date but before you ended your policy with us but which are reported after you end your coverage with us.

Occurrence policies cover incidents that happen while you were covered by a policy issued by The Doctors Company, but can be reported anytime (even if you no longer have a policy with us).

In some states we offer a third option claims-made with Pre-paid Extended Reporting Period "Tail". This option works a lot like an occurrence policy and the cost of the tail coverage is included in your claims-made premium.

If you need additional forms or have any questions about the application, please call your broker/agent, or contact The Doctors Company Member Services at (800) 421-2368.

COVERAGE SELECTION

Please indicate coverage type desired:

☐ Claims-made *(available in all states)*
Covers incidents that take place after the retroactive date and are reported during the policy period.

☑ Occurrence *(Only available in IN, MI, NM, and SC)*
Covers incidents that take place during the policy period regardless of when reported as a claim.

☐ Claims-made with Pre-paid Extended Reporting Period "Tail" *(Only available in MA, MI, and OH)*

IDENTIFYING INFORMATION

1. First name: _____ Middle name: _____ Last name: _____ Suffix: ____ Title: _____
2. Date of birth *(MM/DD/YYYY)*: _____ 3. Social Security number: _____ 4. Gender: ☐ Male ☐ Female
5. E-mail address(es): _____
6. Website address(es): _____ 7. National Provider ID number *(if available)*: _____
8. This application is a ☑ Request to join a physician or group already insured under policy number: _____ *or*
   ☐ New application with The Doctors Company
9. Practice address: Please list all office locations and entities for which you are requesting coverage. Please indicate if they are: hospital, medical office, surgery center, nursing home, urgent care center, correctional facility, etc.
   LAKES URGENT CARE 2300 HAGGERTY RD. STE 1010, W. BIF, MI 48323
10. Office phone number: 248-926-9111 Fax number: 248-926-9112
11. Home address and telephone number: _____
12. Billing address: 2300 HAGGERTY RD. STE. 1010, W. BIF, MI 48323
13. Requested effective date *(coverage start date)*: _____ Requested retroactive date *(prior acts date)*: _____
14. If prior acts coverage is not being requested, are you purchasing extended reporting (tail) coverage from your prior carrier?
    ☐ Yes ☐ No *If yes, please provide proof of tail coverage. If no, please explain in Remarks section.*

PRACTICE INFORMATION

15. Primary specialty: _____ Percentage of practice: _____
    Secondary specialty: Staff Urgen Care Physician Percentage of practice: _____
16. Are you ABMS or AOA Board certified? ☐ Yes ☐ No If yes, date of certification or recertification: _____
17. Are you currently participating in a Maintenance of Certification program? ☐ Yes ☐ No
18. Please indicate your medical license(s): _____ License state(s): _____ Number(s): _____
19. a) Please indicate your average number of practice hours per week that will be covered by this policy, including office hours, administrative activities, direct patient care, surgery, consultation, etc. (excluding on-call): _____
    b) Estimate the number of patients seen on an average weekly basis: _____
20. Current carrier: _____ Number of years with carrier: _____ Current premium: _____
21. Have you ever practiced medicine while you were uninsured? ☐ Yes ☐ No *If yes, please explain in the Remarks section.*
22. Are you affiliated with any other doctor or group? ☐ Yes ☐ No *If yes, please provide information in the Remarks section.*

PRACTICE INFORMATION

23. Do you have locations where you provide or serve as a medical director?

☐ Yes ☐ No

If yes, please provide name and location: _____

24. Do you maintain an ownership interest (in whole or in part) in any entity(ies) related to the practice of medicine (e.g., spa, laboratory)?

☐ Yes ☐ No *If yes, please list name(s) and explain:* _____

25. Do you share office space, employees, billing, or letterhead with any physician?

☐ Yes ☐ No *If yes, provide details in the Remarks section and include supporting documents.*

26. Please list all of your employed or contracted ancillaries, including their titles (please note that if you employ an NP, PA, CRNA, CNM, optometrist, or chiropractor, a separate application and additional information will be required):

Name: _____ Title: _____ Name: _____ Title: _____

INSURANCE INFORMATION

27. Do you supervise ancillaries who are insured elsewhere?

☐ Yes ☐ No *If yes, please provide proof of their insurance.*

28. Please indicate if you are an active member of any medical society or specialty association: _____

29. Please list all hospitals and healthcare facilities at which you have current privileges and the status of those privileges:

_____ _____

_____ _____

_____ _____

30. Please indicate the limits of liability requested (example: $1,000,000 per claim, $3,000,000 annual aggregate):

Per claim: $100,000 Annual aggregate: $400,000

31. Have your limits of liability changed (increased or decreased) in the past three years?

☐ Yes ☐ No *If yes, please indicate your prior limits of liability:* _____

32. Are you involved or do you participate in non-IRB-approved clinical research trials?

☐ Yes ☐ No *If yes, please provide details in the Remarks section and include supporting documents.*

33. Do you have a contract to provide professional services at any nursing home or correctional facility?

☐ Yes ☐ No *If yes, please provide details in the Remarks section and include supporting documents (i.e. your contract with the facility).*

34. Are you now being or have you ever been evaluated for, diagnosed with, or treated for alcohol, narcotics, or any other substance abuse, sexual addiction, anger management issues, or any mental illness?

☐ Yes ☐ No *If yes, please include a letter from your treating physician or institution outlining dates of treatment, results of treatment, and current status, and any agreement you have made with any recovery organization.*

35. Are you aware of any chronic illness or physical defect that impairs or could impair your ability to practice your specialty?

☐ Yes ☐ No *If yes, please include a letter from your treating physician or institution outlining dates of treatment, results of treatment, and current status, and any limitations on your ability to practice the specialty(ies) listed.*

36. Have you ever had professional liability insurance declined, nonrenewed, canceled, or restricted, or have you had an involuntary deductible or surcharge assessed against you? NOTE: MISSOURI APPLICANTS DO NOT RESPOND.

☐ Yes ☐ No *If yes, please provide details in the Remarks section and include supporting documents.*

INSURANCE INFORMATION

37. Have you ever appeared before, been investigated by, entered into any consent agreement with, or do you have an investigation currently in progress or pending by any state licensing board, board of medical examiners, DEA, or other governmental agency?

☐ Yes ☐ No *If yes, please provide copies of complaint and disposition documents.*

38. Has your license to practice or your DEA/narcotics license ever been denied, revoked, suspended, placed on probation, or limited in any way?

☐ Yes ☐ No *If yes, please provide details in the Remarks section and include supporting documents.*

39. Has any physician, patient, or insurance plan ever filed a complaint against you with any medical association/society or foundation, consumer protection agency, Chamber of Commerce, or Better Business Bureau?

☐ Yes ☐ No *If yes, please provide details in the Remarks section and include supporting documents.*

40. Have you ever been arrested, indicted, pled guilty to, or been convicted of any crime other than minor traffic violations not involving any allegation of alcohol or substance use?

☐ Yes ☐ No *If yes, please provide details in the Remarks section and include supporting documents.*

41. Has your participation in any governmental or nongovernmental health program (e.g., Medicare, Medicaid, HMO, PPO, or any managed care program) ever been suspended, placed on probation, terminated, or limited in any way?

☐ Yes ☐ No *If yes, please provide details in the Remarks section and include supporting documents.*

42. Have your staff privileges at any hospital or healthcare facility ever been suspended, refused, revoked, placed on probation, or in any way restricted, or do you have an investigation relative to your staff privileges pending or in progress at any hospital or healthcare facility?

☐ Yes ☐ No *If yes, please provide details in the Remarks section and include supporting documents (i.e. your contract with the facility).*

43. Have you ever withdrawn any application for hospital or healthcare facility staff privileges?

☐ Yes ☐ No *If yes, please provide details in the Remarks section and include supporting documents.*

44. Have you ever been accused of sexual misconduct?

☐ Yes ☐ No *If yes, please provide details in the Remarks section and include supporting documents.*

45. Are you aware of any circumstances that might be reasonably expected to lead to a claim or suit (even if you believe the possible claim or suit would be without merit) that have not been reported to your current or prior medical professional liability carrier?

☐ Yes ☐ No *If yes, please provide details in the Remarks section and include supporting documents.*

46. Have you been a party to a malpractice claim, suit, or incident in the past six years?

☐ Yes ☐ No *If yes, please complete the attached Claim Information form for each claim/incident.*

MEDICAL PROCEDURES

Do you perform any procedures for which you did not receive training in your residency or that are outside the customary scope of practice of your specialty?

☐ Yes ☐ No *If yes, please list the procedures:*

_____

_____

Do you perform bariatric surgery? ☐ Yes ☐ No

Do you operate on the spine? ☐ Yes ☐ No

Do you perform deliveries? ☐ Yes ☐ No *If yes, how many deliveries do you perform per year?* _____

In a hospital: _____ *In a birthing center:* _____ *In a patient's home:* _____

Do you perform in vitro fertilization (IVF)? ☐ Yes ☐ No

Please indicate if you or any of your staff perform the following procedures:

	Physician	Non-Physician Licensed Staff	Non-Licensed Staff
Botox Injection	☐	☐	☐
Chemical Peel	☐	☐	☐
Cosmetic Tattooing	☐	☐	☐
Laser Hair Removal	☐	☐	☐
Laser Wrinkle Removal	☐	☐	☐
Microdermabrasion	☐	☐	☐
Sclerotherapy (Specify procedure _____)	☐	☐	☐
Other Cosmetic Procedures	☐	☐	☐

Please check all procedures that you perform:

- ☐ Abortion
- ☐ Adenoidectomy
- ☐ Anal Fistulectomy
- ☐ Analgesia, IV Conscious Sedation
- ☐ Anesthesia (Spinal)
- ☐ Appendectomy
- ☐ Cesarean Section Delivery
- ☐ Cholecystectomy
- ☐ Circumcision (adult)
- ☐ Circumcision (pediatric only)
- ☐ Closed Reduction (other than simple)
- ☐ Colonoscopy
- ☐ Cryotherapy and LEEPs
- ☐ Culdocentesis
- ☐ Dilation and Curettage
- ☐ Elective Cardioversion
- ☐ Endometrial Biopsy
- ☐ Endoscopic Procedures
- ☐ Hemorrhoidectomy
- ☐ Hydrocelectomy
- ☐ Hysterectomy
- ☐ Laparoscopy
- ☐ Myringotomy
- ☐ Nasal Polypectomy
- ☐ Normal Vaginal Delivery
- ☐ Oophorectomy
- ☐ Orchiectomy
- ☐ Prenatal & Postnatal Care
- ☐ Salpingectomy
- ☐ Tendon Repair
- ☐ Therapeutic Abortion
- ☐ Tonsillectomy
- ☐ Tubal Ligation
- ☐ Vasectomy
- ☐ VBAC
- ☐ Vein Stripping
- ☐ Weight Loss
  - Diet _____
  - Meds _____
- ☐ Other

CARDIOLOGY

- ☐ Cardiac Catheterization
- ☐ Coronary Angiography
- ☐ Coronary Angioplasty/Stents
- ☐ Other

COSMETIC PROCEDURES

- ☐ Abdominoplasty
- ☐ Blepharoplasty
- ☐ Coronal Lift
- ☐ Hair Implant
- ☐ Liposuction
- ☐ Penile-Related Cosmetic Procedure
- ☐ Autologous Fat Injection
- ☐ Breast Augmentation
- ☐ Endoscopic-Assisted Forehead Lift
- ☐ Implants Other than Breast
- ☐ Rhinoplasty (Cosmetic)
- ☐ Rhinoplasty (Functional Only)
- ☐ Thermage
- ☐ Breast Reduction
- ☐ Facial Laser Resurfacing
- ☐ "Lifestyle" Lift
- ☐ Rhytidectomy
- ☐ Sex Reassignment Surgery
- ☐ Other

OPHTHALMOLOGY

- ☐ Medical Treatment Only
- ☐ All Surgical Procedures
- ☐ Limited Surgical Procedures—limited to minor surgical procedures, including:
  - Assisting in Surgery
  - Laser Iridoplasty
  - Laser Trabeculoplasty
  - Laser Ablation
  - Laser Iridotomy
  - Laser Capsulotomy
  - Laser Punctal Closure
  - Other

PAIN MANAGEMENT

- ☐ Block *(spine and non-spine)*
- ☐ Epidural or Spinal Catheter
- ☐ Myofascial Trigger Point Injections
- ☐ Rapid Detoxification
- ☐ Spinal Stimulation Implant
- ☐ Cryoanalgesia
- ☐ Intra-Articular Block *(joint injection)*
- ☐ Nerve Root Injections
- ☐ Spinal Infusion Implant
- ☐ Spinal Stimulation Programming
- ☐ Dorsal Column Stimulator Implants
- ☐ Intradiscal Electrothermal Therapy
- ☐ Radio Frequency Nerve Ablation
- ☐ Spinal Infusion Pump
- ☐ Stellate Ganglion Block
- ☐ Kyphoplasty
- ☐ Vertebroplasty
- ☐ M.I.L.D.
- ☐ Other

NOTE: If there are procedures that are not listed above that you perform, please provide us with a detailed list in the Remarks section or in a separate attachment.

Check it
☐ Not Applicable

CLAIM INFORMATION

This section should be completed only if you answered yes to question #42 on page 5. Please photocopy and complete this form for each additional claim. If more space is needed on each report, continue information on your letterhead. Please write legibly.

1. Name of patient: _____

2. Age: _____ 3. Gender: ☐ Male ☐ Female

4. Relationship to patient (e.g., attending physician, consultant, primary surgeon, assistant surgeon):

_____

5. Allegation: _____

6. Date of incident *(MM/DD/YYYY)*: _____ 7. Location: _____

8. Insurance carrier(s): _____

9. Other defendants: _____

10. Present status: ☐ Open claim Indemnity and expenses reserved: _____
☐ Closed claim Loss of: $ _____ Expenses paid: $ _____
Date closed: _____ ☐ Settlement ☐ Judgment

11. Conditions and diagnosis at time of incident:

_____
_____
_____
_____
_____

12. Dates and description of professional services rendered:

_____
_____
_____
_____
_____

13. Condition of patient subsequent to professional services (and dates of follow-up visits, if known):

_____
_____
_____
_____
_____

REMARKS SECTION

AGREEMENTS

AGREEMENT: I do hereby affirm the truth of all statements and answers, and that I have not intentionally withheld any information that could influence the judgment of the company in considering this application for insurance. I have also made a reasonable inquiry, where appropriate, to ensure the responses herein are as complete and accurate as possible. I understand that any erroneous information or material misrepresentation may cause immediate rescission of my insurance coverage.

AGREEMENT: I understand that no coverage will be bound by the company until such time as I have signed the application and returned the original to the company with the required payment.

AGREEMENT: I understand that in order to underwrite the requested insurance, the company must have access to all possible information concerning my professional conduct and experience. I hereby authorize and direct any medical society, medical doctor, hospital, residency program, insurance company, interindemnity arrangement, underwriter, or insurance agent to furnish any information concerning me or my medical practice that the company may request.

AGREEMENT: Since I understand that the free exchange of information is essential, I agree that any person or organization furnishing information to the company pursuant to this consent and direction, together with the agent, employees, or officers of such person or organization, will not be liable to me in any way for furnishing such information.

AGREEMENT: I agree that this application shall be deemed appended to and a part of, any policy of insurance issued to me based on this application.

AGREEMENT: I further agree that my signature of this application shall be deemed to be a concurrent execution of the attached Subscriber Agreement and Power of Attorney.

SIGNATURE REQUIRED:

X _____ _____

Applicant Signature Date

NOTICES

Notice to Alabama Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Notice to Arkansas Applicants: Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Colorado Applicants: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Notice to District of Columbia Applicants: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Notice to Florida Applicants: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Notice to Kansas Applicants: Any person who knowingly and with intent to defraud any insurance company or other person by presenting any written statement as part of an application for insurance, the rating of an insurance policy, or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto has committed a fraudulent insurance act.

Notice to Kentucky Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Notice to Louisiana Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Maine Applicants: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

Notice to Maryland Applicants: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit, or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Missouri Applicants (Special Non-fraud Notice for Application): An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether any insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question of this nature appears in this application, you should not respond.

Notice to New Jersey Applicants: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICES (CONTINUED)

Notice to New Mexico Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Notice to New York Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. NOTE: The fraud warning statements must be placed immediately above the space provided for the signature of the person executing the application.

Notice to Ohio Applicants: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Notice to Oklahoma Applicants: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. The absence of such a statement shall not constitute a defense in any prosecution.

Notice to Pennsylvania Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Notice to Rhode Island Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Tennessee Applicants: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Notice to Virginia Applicants: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, denial of insurance benefits, and civil damages.

Notice to Washington Applicants: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Notice to West Virginia Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SUBSCRIBER AGREEMENT AND POWER OF ATTORNEY

For and in consideration of similar agreements executed or to be executed by other Subscribers and of the benefits of the exchange of such agreement, the Subscriber agrees to the below-stated terms and conditions.

1. The undersigned subscribes for membership in The Doctors Company, an Interinsurance Exchange ("the Exchange"), and agrees with the Exchange and with other Subscribers, through their Attorney-in-Fact, The Doctors Management Company ("the Attorney"), to exchange with all other Subscribers contracts of liability insurance, or reinsurance, in a form and containing terms and conditions as are approved by the Exchange's Board of Governors.

2. Subscriber designates and appoints the Attorney to be his or her true and lawful agent and Attorney-in-Fact to act in his or her name, place, and stead and in the name of the Exchange, to exchange contracts of insurance and to do all things that the Subscribers might or could do severally or jointly with regard to the operation and management of the Exchange and the business of interinsurance. Subscriber adopts and approves the Management Agreement between the Exchange and the Attorney, as it may be amended from time to time, and of any successor Management Agreement as it also may be amended.

3. Subscriber delegates to the Board of Governors of the Exchange authority to negotiate all the terms and conditions of the Management Agreement between the Exchange and the Attorney on behalf of the Subscriber, including, but not limited to, the compensation to be paid to the Attorney by the Subscriber or Exchange.

4. Subscriber further delegates to the Board of Governors of the Exchange all necessary and proper powers to conduct, manage, and control the affairs and business of the Exchange, subject to those retained by law or through the Rules and Regulations of the Exchange, or as they may be further amended at the Annual Meeting of Subscribers.

5. The Board of Governors is made up of public and professional members elected by a majority of Subscribers present or represented by proxy at the Annual Meeting of Subscribers. Governors generally serve four-year terms. Each year, Governors with expiring terms will stand for election.

6. Subscribership begins with the commencement of the policy period of the liability insurance policy issued by the Exchange and ends upon cancellation or other termination of that policy. The period of subscription shall not include any period of coverage under extended reporting policies or extended reporting or tail coverage endorsements. After termination of subscription, Subscriber shall have no further rights to participate in any distribution of savings to Subscribers or in any distribution of assets upon dissolution of the Exchange.

SUBSCRIBER AGREEMENT AND POWER OF ATTORNEY (CONTINUED)

7. The Board of Governors may appoint any individual, partnership, or corporation to become successor to the Attorney with all of the powers and duties stated in this Agreement. All references to "Attorney" shall then be deemed to include such successor Attorney-in-Fact.

8. The principal offices of the Exchange and the Attorney shall be maintained at Napa, California, or at such other place approved by the Board of Governors.

9. The Agreement can be signed by each Subscriber separately with the same effect as if the signatures of all Subscribers were on one and the same instrument , and signature of the Application to which this Agreement is attached shall constitute signature of this Agreement. This Agreement shall continue in full force and effect until revoked by the written request of Subscriber who has signed this document. This Agreement shall be governed by and interpreted according to the laws of the State of California. All Subscriber Agreements shall be binding upon all Subscribers, and the provision of each shall not materially differ. Wherever the word "Subscriber" is used, it refers to all members of the Exchange, including the Subscriber who has signed this document.

PROXY

I appoint the members of the Board of Governors, and each of them, agents and attorneys with powers of substitution in each of them my lawful proxy to vote and act for me and in my name at all annual, regular, and special meetings of the Subscribers of The Doctors Company, an Interinsurance Exchange.

This proxy is solicited on behalf of the management of the Exchange and will empower the holders to vote on the Subscriber's behalf for the election of members of the Board of Governors and such other business as may properly come before any annual, regular, or special meeting of Subscribers.

This proxy, unless revoked or replaced by substitution, shall remain in force for five years from the date stated below.

You may revoke this proxy by giving the Exchange written notice of your revocation at least 10 days before the date of any annual, regular, or special meeting at which such proxy is to be exercised. If you attend a meeting, you may revoke this proxy if you choose to vote in person.

The signing of this proxy is not a condition of completion of this application and your signature, or your failure or refusal to sign, will not be considered in connection with the underwriting of your application.

SIGNATURE (OPTIONAL):

X _____ _____

Signature Date

Type or print name: _____

Mailing address: _____

City: _____ State: _____ Zip code: _____

INSURANCE APPLICANT BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement is entered into by and between The Doctors Company, an Interinsurance Exchange, including all of its subsidiaries, hereinafter referred to as "we," and "you" in conjunction with the policy of insurance we have entered into with you. This agreement supersedes and replaces any prior Business Associate Agreement ("BAA").

We are committed to comply with the Standards for Privacy of Individually Identifiable Health Information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and as modified by the HITECH provisions of the American Recovery and Reinvestment Act of 2009 and related rules and as may be modified subsequently (the "Privacy Regulations"). Under the Privacy Regulations, you are a "covered entity," and as required by 45 C.F.R. Section 164.502(e) and 45 C.F.R. Section 164.504(e), we acknowledge that we, in certain instances, may be your "business associate." We must use and disclose information that identifies an individual; relates to health, health treatment, or healthcare payment; and is maintained in any form (e.g., electronic, paper, oral) ("Protected Health Information" or "PHI") in our performance of services under this Policy, and we agree to abide by the assurances, terms, and conditions contained herein in the performance of our obligations.

This document sets forth the terms, conditions, and obligations pursuant to which Protected Health Information that is provided, created, or received by us from you or on your behalf, will be handled.

We agree as follows:

A. Permitted Uses and Disclosures of Protected Health Information.

Pursuant to this Agreement, we provide services ("Services") for your operations that may involve the use and disclosure of Protected Health Information as defined by the Privacy Regulations. These Services may include, among others, quality assessment; quality improvement; outcomes evaluation; protocol and clinical guidelines development; reviewing the competence or qualifications of healthcare professionals; evaluating practitioner and provider performance; conducting training programs to improve the skills of healthcare practitioners and providers; credentialing, conducting, or arranging for medical review; arranging for legal services; conducting or arranging for audits to improve compliance; resolution of internal grievances; placing stop-loss and excess of loss insurance; and other functions necessary to perform these Services. Except as otherwise specified herein, we may make any uses of Protected Health Information necessary to perform our obligations under this Agreement. All other uses not authorized by this Agreement are prohibited. Moreover, we may disclose Protected Health Information for the purposes authorized by this Agreement: (i) to our employees, subcontractors, and agents, in accordance with Section D(5) below; (ii) as directed by you in writing; or (iii) as otherwise permitted by the terms of this Agreement. Additionally, unless otherwise limited herein, we are permitted to make the following uses and disclosures:

B. Our Obligations and Activities.

We may use and disclose the Protected Health Information in our possession to third parties for the purpose of our proper management and administration, such as obtaining reinsurance, or to fulfill any of our present or future legal responsibilities, such as complying with insurance regulator requests, provided that (i) the disclosures are required by law; or (ii) we have received from the third party written assurances regarding its confidential handling of such Protected Health Information as required under 45 C.F.R. Section 164.504(e)(4) and where necessary received a BAA.

C. In addition to using the Protected Health Information to perform the services set forth above, we may:

(1) Aggregate the Protected Health Information in our possession with the Protected Health Information of other covered entities that we have in our possession through our capacity as a business associate to said other covered entities, provided that the purpose of such aggregation is to provide you with data analyses relating to your healthcare operations. Under no circumstances may we disclose Protected Health Information of one covered entity as defined by 45 C.F.R. Parts 160 and 164 to another covered entity absent your express written authorization; and

(2) De-identify any and all Protected Health Information provided that the de-identification conforms to the requirements of 45 C.F.R. Section 164.514(b), and further provided that you are sent the documentation required by 45 C.F.R. Section 164.15(b), which shall be in the form of a written assurance from us. Pursuant to 45 C.F.R. 164.502(d)(2), de-identified information does not constitute Protected Health Information and is not subject to the terms of this Agreement.

D. With regard to our use and/or disclosure of Protected Health Information, we agree to do the following:

(1) Use and/or disclose the Protected Health Information only as permitted or required by this Agreement or as otherwise required by law and then only to the minimum necessary extent to accomplish the intended purpose of the use;

(2) Report to your designated Privacy Officer, in writing, any use and/or disclosure of the Protected Health Information that is not permitted or required by this Agreement of which we become aware as soon as practical and within ten (10) business days of our discovery of such unauthorized use and/or disclosure. Where practical and possible, we will take steps to mitigate the harmful effect of any unpermitted disclosure of PHI;

(3) Use commercially reasonable efforts to maintain the security of the Protected Health Information and take appropriate physical, administrative, and technical safeguards to prevent unauthorized use and/or disclosure of such Protected Health Information;

(4) Require all of our subcontractors and agents that undertake to perform the services that we perform under this Agreement and that receive, use, or have access to Protected Health Information under this Agreement to agree, in writing, to adhere to the same restrictions and conditions on the use and/or disclosure of Protected Health Information that apply to us pursuant to this Agreement;

(5) Unless prohibited by attorney-client and other applicable legal privileges or unless it would violate our contractual and other legal obligation to you, make available all records, books, agreements, policies, and procedures relating to the use and/or disclosure of Protected Health Information to the Secretary of the United States Department of Health and Human Services for purposes of determining your compliance with the Privacy Regulations;

(6) Upon prior written request, make available during normal business hours at our offices all records, books, agreements, policies, and procedures relating to the use and/or disclosure of Protected Health Information to you within five (5) business days for purposes of enabling you to determine our compliance under the terms of this Agreement;

(7) We shall honor any request from you for information to assist in responding to an individual's request for an accounting of disclosures of Protected Health Information to us. However, should you be asked for an accounting of the disclosures of an individual's Protected Health Information in accordance with 45 C.F.R. Section 164.528, such accounting should not include any disclosures to us which are to carry out your healthcare operations. See 45 C.F.R. Section 164.528(a)(1)(i);

(8) Upon termination of this Policy, the protections of this Agreement will remain in force and we shall make no further uses and disclosures of Protected Health Information except for the proper management and administration of our business or as required by law;

(9) In those instances when you would be required to honor an individual's request for access and/or amendment of Protected Health Information disclosed to us, we will assist you to comply with your duties under 45 C.F.R. Sections 154.524 and 164.526. However, usually you will not be required to honor such requests because Protected Health Information in our possession is not part of a designated record set as that term is defined by 45 C.F.R. 164.501; and/or because the information is exempt from access and amendment under 45 C.F.R. Sections 164.524(a) and 164.526(a)(2); and/or because access would violate your superseding contractual and other legal rights; and/or because any amendment could be tampering with evidence in a civil or administrative matter;

(10) You may terminate this Agreement by canceling this Policy if we violate a material term of this Agreement;

(11) You agree that we may modify this Agreement as required to comply with applicable laws or regulations.

In witness whereof, The Doctors Company has caused this Agreement to be signed by its Chairman at its Home Office.

Richard E. Anderson, MD
Chairman of the Board of Governors

THE DOCTORS COMPANY

REQUEST TO ADD: MD, PA, NP, CNM, CRNA, OR AUX PHYS

TO The Doctors Company
Underwriting Department

RE Additional Coverage for Policy # _____

Please add _____ to the policy of LAKES URGENT CARE
M.D. or Ancillary Name Group Name

effective _____
Date

He/She will be working:

- [ ] 0 - 10 hours per week
- [ ] 11 - 20 hours per week
- [ ] 21 + hour per week

DOB. Social Security No

If a questions does not apply, simply enter "N/A".

1. Please place _____ in slot # _____
2. This M.D. or Ancillary will.
   - [ ] be sharing limits
   - [ ] have his/her own set of limits
3. Please provide Prior Acts Coverage: [ ] Yes [ ] No
   Retroactive Date Requested: _____

I understand that coverage is not automatic and that **no coverage will be in force** prior to underwriting approval

_____
Signature

_____
Print or type name

_____
Date

BOTSFORD
HOSPITAL

Graduate Medical Education
Moonlighting Request Form

Resident Name: _____

PGY Level: _____ Citizenship or Visa Status: _____ Permanent License Number: _____

Please answer the following questions based on the facility at which you will be moonlighting:

Name of Institution: _____

Address: _____

_____

Telephone: (_____) _____

Name of Employer/Contact Person: _____

Dates of employment and estimated hours: _____

_____

Will you be using Paid Time Off (PTO) for these dates: ☐ YES ☐ NO (check one)

Nature of employment: _____

_____

Liability/Malpractice Insurance Coverage: (Include contractors, policy number and expiration date:

_____

_____

NOTE: You must provide written proof of insurance coverage.

This request is within the guidelines of the Botsford Hospital Medical Education Policy/Procedure, **"Outside Professional Activities (Moonlighting) for Residents"** as outlined in the Botsford Hospital Medical Education Administrative Manual. I am aware that any violation of the **"Outside Professional Activities (Moonlighting) for Residents"** policy/procedure will result in disciplinary action up to and including discharge from Botsford Hospital.

Disclaimer:
I hereby authorize Botsford Hospital Medical Education Office to contact the moonlighting services as indicated above and any others who may have information regarding my employment, hours, duties and supervision and release from liability all representatives of the Medical Education Program Directors, the Medical Education Office and Botsford Hospital for their acts performed in good faith and without malice in connection with evaluating my request for moonlighting privileges. In addition, I release from any liability all individuals and organizations that provide information pertaining to my outside professional activities (moonlighting) in good faith and without malice concerning my request for moonlighting privileges.

I have read and understand the Botsford Hospital Administrative Manual Policy/Procedure for **"Outside Professional Activities (Moonlighting) for Residents"**. I agree to comply with this policy/procedure.

Resident Signature	Date
Program Director Approval	Date
Director of Medical Education Approval	Date

THIS FORM MUST INDICATE APPROVAL BY SIGNATURES OF ALL PARTIES PRIOR TO ANY MOONLIGHTING ACTIVITIES.

Submit by Email