PHYSICS AND ALLIED HEALTH
LOCUM TENENS PRACTICE PROFILE

Date			
Client Name			
Client Contact		Title	
Client Address			
County			
Client Phone		Fax	
Client Website		Client Email	
Worksite Name			
Worksite Contact		Title	
Worksite Address			
Worksite Phone		Fax	

PRACTICE INFORMATION

Is this practice	multi-specialty group ☐	single specialty group ☐	solo ☐
	private practice ☐	hospital-based ☐	freestanding ☐

Who will review with the locum tenens provider client policies and procedures, introduce hospital staff, and give a briefing of patients currently under treatment?	Name		Phone	( )
Does your state require the provider to be licensed?	☐ Yes ☐ No			
Will the provider need to be added to an NRC Permit?	☐ Yes ☐ No			
Are there any state nuclear regulatory requirements we need to be aware of?	☐ Yes ☐ No			
What are they?				
Please complete the following as it pertains to the locum tenens provider.	Avg. number of sims per week			

Avg. number of treatments per day		Avg. number of consults per week	
Avg. number of follow-ups per week		Number of new R.T. patients last year	
Is there a second practice location to be covered?	☐ Yes ☐ No	Distance from main site	

TECHNICAL, CLINICAL, AND SUPPORT STAFF

Number of RTTs		Chief Tech's Name	
Number of RTs		Dosimetrist's Name	
Physics Support	☐ Fulltime ☐ Parttime ☐ MS ☐ PhD	Days covered	
Physicist's Name			
Radiation Safety Officer		Phone	

Number of RNs		Number of LPNs		Office Manager's Name	
Administrator's Name				Transcriptionist	☐ Fulltime ☐ Parttime

CANCER CAREPOINT
nationwide staffing services

HOSPITAL INFORMATION

Please list all the hospitals your practice is affiliated with.					
1. Name					
Contact					
Address					
Phone		Fax		Distance from main office	
2. Name					
Contact					
Address					
Phone		Fax		Distance from main office	
3. Name					
Contact					
Address					
Phone		Fax		Distance from main office	

EQUIPMENT

Type of Accelerator		Energies	
Type of Accelerator		Energies	
HDR (Brand/Type)		Superficial Unit	
Type of Simulator		With flouro?	☐ Yes ☐ No
Treatment Planning Computer			
Services	☐ IMRT ☐ IGRT ☐ Gamma Knife ☐ CyberKnife ☐ Brachytherapy ☐ MammoSite ☐ PET/CT		
	☐ TomoTherapy ☐ 3D CRT ☐ SRS ☐ SRT ☐ HDR/LDR		
Other			
Describe tasks you do not want the provider performing?			

COMMUNITY INFORMATION

Service Area Population		City Population	
Nearest major airport		Nearest commuter airport	
What are the local attractions?			

ACCOMMOCATIONS FOR PROVIDER

Do you want us to make accommodations for the provider?	☐ Yes ☐ No		
If so, do you have a preference?			
Name			
Address			
Phone			
How far from main office?		Cooking amenities available?	☐ Yes ☐ No

ADDITIONAL INFORMATION

What else do we need to share with our provider about your request for coverage?

LOCUM TO PERM ONLY

Please provide the salary range for this position			
Do you offer a bonus?	☐ Yes ☐ No	How is it calculated and distributed?	
Check which insurance is paid for	☐ malpractice health: ☐ family ☐ single ☐ life ☐ disability ☐ dental		
How much vacation time?		How much CME time?	
Do you offer a retirement plan?	☐ Yes ☐ No	What type?	
Do you provide relocation assistance?	☐ Yes ☐ No	Do you have an auto allowance?	☐ Yes ☐ No
What other benefits do you offer?			

Please ensure that our provider becomes familiar your policies and procedures, introduce staff, and give a briefing of patients currently under treatment. If possible, it is more beneficial if our physician is given orientation the day prior to coverage starting.

Client	
Signature	
Title	
Date	