



**MEDICAL ONCOLOGY
DATES REQUESTED FOR LOCUM TENENS COVERAGE**

Client Name	
Facility	
Address	

DATES REQUESTED

Location 1					
From		To		Office Hours	
From		To		Office Hours	
From		To		Office Hours	
From		To		Office Hours	
From		To		Office Hours	
Location 2					
From		To		Office Hours	
From		To		Office Hours	
From		To		Office Hours	
From		To		Office Hours	
From		To		Office Hours	

CALL RESPONSIBILITY

Will physician rotate call with others?	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
Will physician be asked to take call for specialists other than oncologists?	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
Will the physician take night call?	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
If yes, please indicate the evenings the physician will take night call.	M <input type="checkbox"/>	Tu <input type="checkbox"/>	W <input type="checkbox"/>	Th <input type="checkbox"/>	F <input type="checkbox"/>
Night Call Hours					
Will the physician take weekend call?	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
If yes, please indicate the weekends the physician will take call.					
Weekend Call Date		Weekend Call Hours			
Weekend Call Date		Weekend Call Hours			
Weekend Call Date		Weekend Call Hours			
Weekend Call Date		Weekend Call Hours			

Client	
Signature	
Title	
Date	