



MEDICAL ONCOLOGY
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	
Number of office locations our physician will cover			
Location		Phone	
Location		Phone	

PRACTICE INFORMATION

Is this practice	multi-specialty group <input type="checkbox"/>	single specialty group <input type="checkbox"/>	solo <input type="checkbox"/>
	private practice <input type="checkbox"/>	hospital-based <input type="checkbox"/>	freestanding <input type="checkbox"/>
Physician who Cancer CarePoint will be covering for			
Number of oncologists in practice			
Names of staff physicians & specialties			
Is it REQUIRED for the locum physician to be board certified?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Will other oncologists be present during the locum tenens coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Physician's Name		Office Phone	
Beeper		Home Phone	
Will a physician be available to orient our doctor to the practice?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If not, who will review with the locum tenens physician client policies and procedures, introduce hospital staff, and give a briefing of patients currently under treatment?			
	Name		Phone
Please complete the following as it pertains to the locum tenens physician.			
Avg. number of new consults per week		Avg. number of scheduled patients per day	
Avg. number of follow-ups per day		Avg. number of office chemo patients per week	
Avg. number of inpatients per day		Who administers chemo?	
Avg. new admissions per week			



PRACTICE INFORMATION (cont.)

Does the practice include:						
Internal Medicine	<input type="checkbox"/>	Percent		Hematologic Oncology	<input type="checkbox"/>	Percent
Pediatric Oncology	<input type="checkbox"/>	Percent		Gynecologic Oncology	<input type="checkbox"/>	Percent
Bone Marrow Transplant	<input type="checkbox"/>	Percent		Stem Cell Transplant	<input type="checkbox"/>	Percent
Where are chemo drugs mixed?						
Where are x-rays taken?						
Where is lab work done?						
Where is the closest blood bank located?						
Is there documentation of the more routine chemo regimens given?				<input type="checkbox"/> Yes <input type="checkbox"/> No		
Will our physician be asked to consider patients for protocols/clinical trials?				<input type="checkbox"/> Yes <input type="checkbox"/> No		

OFFICE STAFF

Number of RNs		Number of LPNs	
Number of NPs		Number of PAs	
Office Manager		Data Collector	

HOSPITAL INFORMATION

Will the physician require hospital privileges?				<input type="checkbox"/> Yes <input type="checkbox"/> No		
Hospital(s) where our physician will make rounds						
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		
Nearest Radiation Therapy						
Will physician attend tumor board meetings?			<input type="checkbox"/> Yes <input type="checkbox"/> No		When are they held?	
Where are they held?						

LOCUM TO PERM ONLY

Please provide the salary range for this position			
Are you offering an income guarantee?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How is it structured?	
Do you offer a bonus?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How is it calculated and distributed?	
Do you offer partnership?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If there is a buy-in, how much is it?	
Check which insurance is paid for	<input type="checkbox"/> malpractice health: <input type="checkbox"/> family <input type="checkbox"/> single <input type="checkbox"/> life <input type="checkbox"/> disability <input type="checkbox"/> dental		
How much vacation time?		How much CME time?	
Do you offer a retirement plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	What type?	
Do you provide relocation assistance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have an auto allowance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What other benefits do you offer?			

COMMUNITY INFORMATION

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

ACCOMMODATIONS FOR PHYSICIAN

Do you want us to make accommodations for the physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If so, do you have a preference?			
Name			
Address			
Phone			
How far from main office?		Cooking amenities available?	<input type="checkbox"/> Yes <input type="checkbox"/> No

ADDITIONAL INFORMATION

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

Please ensure that our oncologist becomes familiar with the physician referral system, prescription policies, charting and billing procedures, and meets with appropriate hospital contacts, etc. If possible, it is more beneficial if our physician is given orientation the day prior to coverage starting.

Client	
Signature	
Title	
Date	