

**RADIATION ONCOLOGY  
LOCUM TENENS PRACTICE PROFILE**

Date			
Client Name			
Client Contact		Title	
Client Address			
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	
Office Hours			

**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 radiation oncologists on staff			
Names of other physician in the practice			
Will other radiation 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	
Is it <b>REQUIRED</b> for the locum physician to be board certified?			<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Please complete the following as it pertains to the locum tenens physician:</b>			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	
Will our physician be asked to consider patients for protocols/clinical trials?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any state nuclear regulatory requirements we need to be aware of?			<input type="checkbox"/> Yes <input type="checkbox"/> No
What are they?			

**TECHNICAL, CLINICAL, AND SUPPORT STAFF**

Number of RTTs		Chief Tech's Name	
Number of RTs		Dosimetrist's Name	
Physics Support	<input type="checkbox"/> Fulltime <input type="checkbox"/> Parttime	<input type="checkbox"/> MS <input type="checkbox"/> PhD	Days covered
Physicist's Name			
Radiation Safety Officer			Phone
Number of RNs	Number of LPNs	Office Manager's Name	
Administrator's Name		Transcriptionist	<input type="checkbox"/> Fulltime <input type="checkbox"/> Parttime

**HOSPITAL INFORMATION**

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

**EQUIPMENT**

Type of Accelerator	Energies
Type of Accelerator	Energies
HDR (Brand/Type)	Superficial Unit
Type of Simulator	With fluoro? <input type="checkbox"/> Yes <input type="checkbox"/> No
Treatment Planning Computer	
Services	<input type="checkbox"/> IMRT <input type="checkbox"/> IGRT <input type="checkbox"/> Gamma Knife <input type="checkbox"/> CyberKnife <input type="checkbox"/> Brachytherapy <input type="checkbox"/> MammoSite <input type="checkbox"/> PET/CT
	<input type="checkbox"/> TomoTherapy <input type="checkbox"/> 3D CRT <input type="checkbox"/> SRS <input type="checkbox"/> SRT <input type="checkbox"/> HDR/LDR
Other	
Describe tasks you do <u>not</u> want the physician performing?	

**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?

**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?			

**Please ensure that our oncologist 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	