

MEDICAL & ALLIED SERVICE REQUEST FORM

Requestor Information							
Requesting Agency / Facility							
Assignment Location Address							
Requestor Name							
Requestor Contact Information		Phone				Email	
Position Information							
Position Title Requested							
Job Description and Duties (please describe or attach Job Description)							
Type of Assignment	☐ Per-Diem ☐ Part-Time ☐ Full-Time ☐ Contract ☐ Locum Tenens						
Duration of Assignment (i.e., 13-weeks, ongoing)							
Start Date							
Schedule - Days	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Schedule - Hours							
Holidays	Holiday Pay (at 1.5x bill rate) for hours worked on State observed holidays ☐ Yes ☐ No						
Overtime/Premium Pay	Paid in accordance with State and Federal guidelines ☐ Yes ☐ No						
Methodology	☐ Agency Negotiated *if agency negotiated, skip Provider Pay Rate ☐ Contract with referral (bill rate is pay rate+24.2%) *complete Provider Pay Rate ☐ Contract with no referral (bill rate is pay rate+28.2%) Pay rate determined by Agency upon placement						
Is requestor referring a candidate?	☐ No ☐ Yes (please provide resume, if available)						
Candidate Name							
Candidate Contact Information	Phone				Email		
Pay Rate for Position	\$						
Bill Rate to Requesting Agency	\$						
Contact for Invoicing	Name				Phone		Email
Time & Attendance Approver	Name				Phone		Email
AP/Business Office Contact	Name				Phone		Email
Approval Signatures							
Requested By				Date			
Requestor Signature							
Approved By				Date			
Approval Signature							