**INDEPENDENT CONTRACTOR**

**UNIVERSAL MEDICAL RECORD**

EFFECTIVE DATE: \_\_ \_\_ /\_\_ \_\_/\_\_ \_\_ \_\_ \_\_

APPLICANT NAME: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

STREETADDRESS: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

CITY/TOWN STATE ZIP CODE: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

PHONE (H) (\_\_ \_\_ \_\_) - \_\_ \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_ PHONE (C) (\_\_ \_\_ \_\_) - \_\_ \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_

CONTRACTORS BUSINESS NAME: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

STREET ADDRESS: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

CITY/TOWN STATE ZIP CODE: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

OFFICE PHONE (\_\_ \_\_ \_\_) - \_\_ \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_

NAME OF FACILITY NAME: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

STREETADDRESS: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

CITY/TOWN STATE ZIP CODE: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

OFFICE PHONE (\_\_ \_\_ \_\_) - \_\_ \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_

JOB TITLE/POSITION: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

Rate of Pay or Compensation: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ Hours Per Week: \_\_ \_\_ Days Per Week: \_\_ \_\_

Check List: Must Have the Following Insurance

Name of General Liability Insurance \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ Policy No:\_\_ \_\_ \_\_ \_\_ \_\_ \_

Name of Malpractice Insurance \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ Policy No:\_\_ \_\_ \_\_ \_\_ \_\_ \_

Name of Workers Compensation Insurance \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ Policy No:\_\_ \_\_ \_\_ \_\_ \_\_ \_

Name of Disability Insurance \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ Policy No:\_\_ \_\_ \_\_ \_\_ \_\_

**INDEPENDENT CONTRACTOR UNDERSTANDS THE ABOVE CONDITIONS AND ALSO AGREES TO THE FOLLOWING:**

**• Contractor understands their work as an independent contractor and receives a 1099**

**• There are NO BENEFITS – Contractor will obtain and maintain their own General Liability,**

**Malpractice, Workers Compensation and Disability Insurances**

**• Contractor establishes their own work schedule, hours and days**

**• Contractor CANNOT file for unemployment or any other BENEFITS**

**• Contractor works for AGENCY on a nonexclusive basis**

**• Contractor is fully informed with UMR’s mission statement, code of ethics and best practices.**

**• Contractor is fully informed with the facility’s work policies, procedures and conduct and has duly**

**executed their signature on same**

**• Contractor will formally notify in writing, email, or text of any issue(s) incurred when they are**

**working at their current facility within 48 hours of any occurrence. This includes any policy and/or**

**procedural issue(s) that may be compromised**

This Agreement constitutes the entire Agreement between Agency and Contractor with respect to the subject matter hereof and supersedes any and all other Agreements, either oral or in writing, between the parties hereto with respect to the subject matter thereof. This Agreement shall be binding upon the successors or assigns of the parties hereto In **WITNESS WHEREOF,** Contractor and Agency have hereunto caused this Agreement to be executed as by laws provided, the date and year first above written

CONTRACTOR SIGNATURE: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ DATE: \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_

AUTHORIZED BY:\_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ DATE: \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_