RELIABLE
HEALTH CARE SERVICES

Certified by The Joint Commission

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			

Please return this form to nvorders@reliablehc.com or Fax 702-221-1036