



# Per Diem Agreement

<b>CLINICIAN INFORMATION</b>	<b>DATE:</b> <input style="width: 150px; height: 30px;" type="text"/>
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**Full Address:**

**Full Name:**

**Phone:**

**E-Mail:**

**Rate:**  **CP**  
**\$35 Per Visit**     **Phlebotomist**

Mileage: Not reimbursed

<b>COVERAGE LOCATIONS</b>	<b>NOT-DESIRED LOCATIONS</b>
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**SPECIAL SKILLS**

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	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
<b>BASE AVAILABILITY</b>							

We require 2 week notice to change your base schedule to safely redirect patients. \*See field employee standards handbook for details\*

Make sure you have read and understood the payroll & route sheets documents & explanation

**NAME (Print)** \_\_\_\_\_

**TITLE** \_\_\_\_\_

**SIGNATURE** \_\_\_\_\_