PHYSICIAN RECRUITMENT/REFERRAL REWARD PROGRAM
SUBMISSION FORM

Name of person submitting the candidate referral: _____

Name: _____

Address: _____
Street City State Zip

Current Date: _____ Phone: _____

E-mail address: _____

Physician Information

Name: _____

Home Phone: _____Cell Phone: _____

E-mail address: _____

Referring physician for Family Practice with OB experience

Resume/Curriculum Vitae attached: _____ Yes _____ No

Candidate submission approved for referral reward: _____ Yes _____ No

If no, reason for inelilgibility: _____

For Physician Recruitment Use

Reward Amount Approved $ _____ Notified date/initials_____

_____ _____
Signature 1st Approval Date

_____ _____
Signature 2nd Approval Date

For Human Resources' Use

Physician Candidate Start Date: _____
Complete 30 days of employment: $2,000 1st pmt due: _____ Paid date: _____
Complete 6 mos. of employment: $3,000 1st pmt due: _____ Paid date: _____
Complete 1 year of employment: $5,000 1st pmt due: _____ Paid date: _____