



SHIFT RESERVATION FORM

Please complete and sign the form then fax to (303) 800-8239 or email admin@extramd.com. For offices without a signed contract, one will be emailed to the contact before processing the Shift Reservation Form.

Practice Name: _____

Street address: _____

City: _____ Zip: _____

Contact: _____ Phone: _____

Email: _____

Family Practice Physicians Internal Medicine Physicians FP and IM physicians

If requesting a specific Physician, please provide name: _____

Dates and Hours for staffing requested by Client (**each shift must be minimum of 8 hours**):

Date	Time	Date	Time

If you would like an emailed status update, provide email address and date by which you wish to be updated. Email: _____ Date of Update: _____

Client agrees the above dates and hours are correct. Each shift must be a minimum of 8 hours. Client will be invoiced \$100 for each scheduled shift when notified via email that a physician has been scheduled. This deposit is non-refundable. All changes to shifts must be emailed within 24 hours to admin@extramd.com. Shifts cancelled less than 45 days notice for which an ExtraMD physician has been scheduled will be charged the full 8 hour rate for each cancelled shift. Client shall be invoiced for all cancellation fees.

Client signature: _____ Date: _____