

Wichita
RESIDENT LOCUM TENENS REQUEST
(To be submitted no less than 2 weeks prior to planned activity)

1. Approval is requested for _____ to
Name of Resident PGY-level
 participate in a locum tenens activity (for compensation) during time that he/she
 is not required to participate in his/her residency program sponsored by the UKSM-W.

2. This locum tenens will occur for:

Name of Physician	Location of Physician's Office <small>clinic or hospital</small>	Date(s)	Time(s)
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3. Reason for physician's absence (i.e. illness, vacation, CME, etc.)

4. Reason why resident coverage via locum tenens is more appropriate than coverage via
 another community physician. (use a separate sheet if necessary) _____

5. The resident has a full license issued by the Kansas State Board of Healing Arts and has
 an individual DEA registration number.

License # _____ DEA registration # and expiration date

6. As Program Director, I recommend that this activity be covered by the resident's
 professional liability insurance provided via the State of Kansas.

Program Director's Signature	Date
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7. I request permission to participate in the locum tenens activity identified above. I
 understand that it constitutes an extracurricular activity falling outside the confines of my
 formal residency program, but that, if approved, it is to be covered by my state-provided
 professional liability insurance.

Resident's Signature	Date
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FORWARD ALL COPIES TO:
Wichita Center for
Graduate Medical Education
1010 N. Kansas
Wichita, KS 67214-3199

*** Approved by:

Chief Operating Officer	Date	Executive Vice Chancellor – KUMC	Date
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Following Approval:
 white copy: GME yellow copy: Program Director pink copy: Resident