

REQUEST FOR LOCUM COVERAGE

Coverage by Locum Tenens staff is only permitted for vacation, Board approved leave of absence or prolonged illness. *(If request is to cover for illness, the LDH may complete the form)*

A minimum of 2 weeks is required for processing this form, once providers complete information has been received.

PERSONAL INFORMATION			
Full Legal Name:	MSP Number:	Primary Email Address:	
LICENSURE & MALPRACTICE INFORMATION			
BC College License #:	License Type:	Malpractice Insurance Policy Number:	Code:
APPLICATION DETAILS			
Site(s) of coverage: Primary Site: Other Site(s):	Department:	Division:	
Name of the Medical Staff Member Requesting Coverage:		Dates Requested: Start: _____ End: _____	
Provide details for the request below:			
Admitting Privileges required: Yes No Date of last State covered:			
Coverage of Clinics required: Yes No Date of last Clinic covered:			
<b style="color: red;">In the space provided, include reason coverage is required, dates office closed (if any), dates rostered for Call coverage:			
<i style="color: red;">Note: Members may not be appointed solely for the purpose of covering the call shifts of a Provisional/Active Member, however coverage for call shifts may be a part of the need that they are addressing as part of their appointment.</i>			

_____	_____	_____	_____
Applicant Signature	Date	Signature of Member Requesting Locum <i>(if applicable)</i>	Date

APPROVAL			
By signing below, I am indicating approval for the request as detailed above.			
<i>Additional Notes:</i>			
Local Department Head	Department	Leader Name	Signature
_____	_____	_____	_____
Date	Date	Date	Date