



# Wyoming Health Resources Network, Inc.

A public/private partnership dedicated to improving rural health

## Physician Vacancy Listing

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Date Needed

\_\_\_\_\_  
Date Vacancy Listed

\_\_\_\_\_  
Recruiting Entity

\_\_\_\_\_  
Contact Name

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Email Address

### POSITION INFORMATION

Permanent position  Locum Tenens for the following dates: \_\_\_\_\_

Specialty desired: \_\_\_\_\_

Reason for vacancy: \_\_\_\_\_

Type of practice:  Solo  Single Specialty  Multi Specialty  Employed

Other (please explain) \_\_\_\_\_

Are you recruiting for a specific physician or group? \_\_\_\_\_

	Required	Preferred	No preference
M.D.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.O.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Board Certified	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Board Eligible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
International Medical Graduate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resident/Fellow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician in practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High risk OB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C-Section	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please describe \_\_\_\_\_

Will you consider a J-1 visa physician?  Yes  No

How many years practice experience required/preferred? \_\_\_\_\_

Specific medical skills required/preferred? \_\_\_\_\_

Hospital privileges required?  Yes  No

Number of patients seen in the practice/department last year? \_\_\_\_\_

Number of patients seen daily? \_\_\_\_\_

Please describe week night call: \_\_\_\_\_

Please describe weekend call: \_\_\_\_\_

Please describe ER responsibilities: \_\_\_\_\_

**INCOME INFORMATION**

Position is:  employment arrangement Employer: \_\_\_\_\_

Salary: \$ \_\_\_\_\_

Contract Income Guarantee: \_\_\_\_\_

Who provides guarantee? \_\_\_\_\_

Projected annual income: \$ \_\_\_\_\_

Are there any incentives?  Yes  No If yes, please explain: \_\_\_\_\_

**BENEFITS**

- Malpractice insurance
- Vacation How much? \_\_\_\_\_
- Health insurance for physician
- Health insurance for family
- Dental insurance for physician
- Dental insurance for family
- Time for CME How much? \_\_\_\_\_
- Moving expenses How much? \_\_\_\_\_
- Financial planning assistance
- Life insurance
- Disability insurance
- Personal umbrella liability
- Membership dues Specify: \_\_\_\_\_
- Book purchase allotment
- Corporate partner. Date: \_\_\_\_\_
- Loan repayment. Describe: \_\_\_\_\_

**FACILITIES RELATED TO THIS POSITION**

Hospital/facility: \_\_\_\_\_ Ownership: \_\_\_\_\_

No. of Beds: \_\_\_\_\_ Swing beds: \_\_\_\_\_

Admissions per year: \_\_\_\_\_ Average daily census: \_\_\_\_\_

Please describe hospital privileges: \_\_\_\_\_

Where will physician be located? \_\_\_\_\_

Please describe office arrangement (# of exam rooms, other providers in same location, support staff, etc.): \_\_\_\_\_

Satellite locations: \_\_\_\_\_ Frequency: \_\_\_\_\_

**DEMOGRAPHIC INFORMATION**

Size of town: \_\_\_\_\_ Size of medical service area: \_\_\_\_\_ County population: \_\_\_\_\_

Designated HPSA  Yes  No

USPH/NHSC Loan Repayment site?  Yes  No

USPH/NHSC Scholarship site?  Yes  No

Area attractions (schools, churches, cultural attractions, recreation, and other attractions): \_\_\_\_\_

**MEDICAL STAFF INFORMATION**

Number of physicians located at your site: \_\_\_\_\_

Number of Support staff and type (RN, PA, NP, technicians, etc.): \_\_\_\_\_

Names and ages of physicians at your site: \_\_\_\_\_

Number and specialties of community physicians/providers: \_\_\_\_\_

Are any organizations competing with your facility in recruiting?  Yes  No

Please describe: \_\_\_\_\_

Is there any resistance to your recruiting efforts?  Yes  No

Please describe: \_\_\_\_\_

Any other pertinent information that a candidate should know about your opportunity: \_\_\_\_\_

**Thank you for selecting Wyoming Health Resources Network, Inc. for your recruitment needs.**

**Email or Mail completed form to:**

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