

## DOCUMENT CHECKLIST

The following documents are **REQUIRED** to complete your application:

- Physician Application
- Completed Delineation of Privileges Form
- Signed W-9
- Copy of Your Current Curriculum Vitae
- Photocopy of Your Medical School Diploma
- Photocopy of Internship, Residency and Fellowship Certificates
- Photocopy of Board Certificates
- ECFMG (If Applicable)
- Photocopies of **EACH** Current State Medical License  
(*Wallet card with expiration date and number – **NOT** the wall certificate*)
- Photocopies of State Controlled Substance Permits, If Applicable
- Photocopy of Federal DEA
- Current Photograph Signed and Dated in the margin
- Copy of Your Driver's License or Passport  
Please provide your UPIN, Medicaid, Medicare and Other Provider Numbers that may apply.
- TB Skin Test, Rubella or Rubeolla Test Results
- NPI Number and Confirmation Letter
- Proof of Mammography Readings (Radiologist – If Applicable)
- CME's for the Past Two Years
- Locum Tenens Practice Experience (If Applicable)
- Authorization for Direct Deposit (If Preferred)
- Malpractice Claims History Form (If Applicable)



2655 Northwinds Pkwy  
Alpharetta, GA 30009  
Toll Free: 1.800.locummd  
Fax: 770.643.5797  
Web: www.LocumTenens.com

**ATTACH CURRENT PHOTO HERE.  
INDICATE DATE TAKEN  
AND SIGN IN INK ACROSS THE BOTTOM  
OF PHOTO.**

*Note: Photo must be:*

1. Original
2. No larger than 3 by 4 inches
3. Taken within one year of application
4. Close-up view of self – not profile
5. Instant Polaroid photographs not acceptable

#### PHYSICIAN APPLICATION

For Dr.: \_\_\_\_\_

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

Date: \_\_\_\_\_

Availability: When are you available to work? \_\_\_\_\_

Where would you prefer to work? \_\_\_\_\_

How many weeks would you like to work Locum Tenens? \_\_\_\_\_

How did you become aware of us? \_\_\_\_\_

Approved: \_\_\_\_\_

*Medical Director*

**PLEASE TYPE OR PRINT IN BLACK INK: *Please attach your Curriculum Vitae***

Name _____	Specialty _____
Home Address _____	Home Phone _____
City/State/Zip _____	Work Phone _____
Date of Birth _____ Place of Birth _____	Beeper _____
Social Security Number _____	Cell Phone _____
Present Position _____	E-mail Address _____
UPIN# _____ NPI# _____ Medicare # _____	Citizenship _____
Medicaid # _____ Federal Tax ID # _____	

**PREMEDICAL EDUCATION**

School of Graduation _____	City/State _____
Major _____ Degree _____	Dates Attended From _____ to _____

**MEDICAL EDUCATION: *Please list all institutions attended. Use separate sheet if necessary.***

School of Graduation _____	
Street Address _____	
City/State/Zip _____	Dates Attended From _____ to _____

**RESIDENCY: *Please list all institutions attended. Use separate sheet if necessary.***

**PGY I  
(Internship)**

Hospital _____	
Street Address _____	
City/State/Zip _____	Dates attended from _____ to _____
Specialty _____	Program Director _____
Additional Training _____	

**PGYII**

Hospital _____	
Street Address _____	
City/State/Zip _____	Dates attended from _____ to _____
Specialty _____	Program Director _____
Additional Training _____	

**PGYIII**

Hospital _____	
Street Address _____	
City/State/Zip _____	Dates attended from _____ to _____
Specialty _____	Program Director _____
Additional Training _____	

**PGYIV or Fellowship**

Hospital _____	
Street Address _____	
City/State/Zip _____	Dates attended from _____ to _____
Specialty _____	Program Director _____
Additional Training _____	

**PRACTICE EXPERIENCE**

List professional experience in chronological order. Please include active military duty. Attach separate sheet if necessary.

1. Practice Location \_\_\_\_\_ Dates from \_\_\_\_\_ to \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_ Contact Person \_\_\_\_\_  
2. Practice Location \_\_\_\_\_ Dates from \_\_\_\_\_ to \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_ Contact Person \_\_\_\_\_  
3. Practice Location \_\_\_\_\_ Dates from \_\_\_\_\_ to \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_ Contact Person \_\_\_\_\_

**HOSPITAL PRIVILEGES**

List all hospital privileges you have held except for Residency or Fellowship programs. Please list all dates. Attach separate sheet if necessary.

1. Hospital Name \_\_\_\_\_ Dates from \_\_\_\_\_ to \_\_\_\_\_  
Hospital Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
2. Hospital Name \_\_\_\_\_ Dates from \_\_\_\_\_ to \_\_\_\_\_  
Hospital Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
3. Hospital Name \_\_\_\_\_ Dates from \_\_\_\_\_ to \_\_\_\_\_  
Hospital Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
4. Hospital Name \_\_\_\_\_ Dates from \_\_\_\_\_ to \_\_\_\_\_  
Hospital Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_

List all hospital privileges you have held except for Residence of Fellowship programs. Please list all dates chronologically from most recent to initial. Attach separate sheet if necessary.

**MILITARY EXPERIENCE**

Branch of Service \_\_\_\_\_ Date of Discharge \_\_\_\_\_ Type of Discharge \_\_\_\_\_

**CERTIFICATION**

FLEX # \_\_\_\_\_ Total Score \_\_\_\_\_ # Times Taken \_\_\_\_\_ Date Passed \_\_\_\_\_  
National Boards Part III, # \_\_\_\_\_ Date \_\_\_\_\_  
USMLE # \_\_\_\_\_ # Times Taken \_\_\_\_\_ Date Passed \_\_\_\_\_  
State Boards of \_\_\_\_\_ Date \_\_\_\_\_  
ECFMG or FMGEMs, # \_\_\_\_\_ Date \_\_\_\_\_  
Board Certified Yes \_\_\_\_\_ No \_\_\_\_\_ By What Board \_\_\_\_\_ Issued \_\_\_\_\_ Certification # \_\_\_\_\_  
Re-Certification Yes \_\_\_\_\_ No \_\_\_\_\_ When \_\_\_\_\_  
Board Eligible Yes \_\_\_\_\_ No \_\_\_\_\_ Expires \_\_\_\_\_  
If yes, have you completed and passed your written examination? Yes \_\_\_\_\_ No \_\_\_\_\_ Date of Exam \_\_\_\_\_  
If no, when are you scheduled to take the examination? Date of Exam \_\_\_\_\_  
ATLS Yes \_\_\_\_\_ No \_\_\_\_\_ Expires \_\_\_\_\_  
ACLS Yes \_\_\_\_\_ No \_\_\_\_\_ Expires \_\_\_\_\_  
BLS Yes \_\_\_\_\_ No \_\_\_\_\_ Expires \_\_\_\_\_  
PALS Yes \_\_\_\_\_ No \_\_\_\_\_ Expires \_\_\_\_\_  
NNALS Yes \_\_\_\_\_ No \_\_\_\_\_ Expires \_\_\_\_\_

**PROFESSIONAL SOCIETIES: Please list all memberships.**

**CONTINUING MEDICAL EDUCATION**

On a separate sheet, list postgraduate activities attended or for which you have received credit in the past two years. List scientific papers or essays you have written. Do not include meetings attended as part of residency training.



ADDITIONAL INFORMATION

Do you have current professional liability insurance? Yes No Policy #
Company Coverage Limits

If the answer to any of the following questions is "yes", please give details on a separate sheet.

- 1. Has your license to practice medicine in any jurisdiction ever been surrendered, limited, suspended to revoked?
2. Have you ever been refused membership on a hospital medical staff?
3. Has your request for any specific clinical privilege ever been denied or granted with state limitations?
4. Have your privileges at any hospital ever been suspended, diminished, revoked or not renewed?
5. Have you ever surrendered a narcotics registration or has one ever been limited, suspended, or revoked?
6. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medication organization?
7. Have you ever been subject to a Medical Malpractice Claim?
8. Have you ever received treatment for alcoholism, drug abuse, or psychiatric disorders?
9. Have you ever been convicted of a felony?
10. Have you ever been denied a medical license?
11. Has your Medicare or Medicaid participation ever been suspended or revoked?
12. Have you ever voluntarily surrendered, limited or suspended your license to practice medicine in any jurisdiction, under threat of investigation, order of consent invoked by any jurisdiction, or as a settlement to an investigation by a jurisdiction in lieu of threatened mandated revocation or suspension?
13. Have you ever voluntarily surrendered, limited or suspended your privileges at any hospital under threat of investigation, order of consent invoked by any hospital or as a settlement to an investigation by a hospital in lieu of threatened mandated revocation or suspension?
14. Have you ever voluntarily surrendered, limited or suspended your state or federal narcotics registration under threat of investigation, order of consent invoked by any state or the federal government or as a settlement to an investigation by a state or the federal government in lieu of threatened mandated revocation or suspension?
15. Have you ever been denied, revoked, or had cancelled your Malpractice Insurance?

Please provide the name and address of someone who will always know your forwarding address.

Name Phone
Address City/State/Zip

Applicant agrees 1) that the information contained herein and the reference obtained and verification received in connection with processing this application may be disclosed to any professional insurance company, hospital or healthcare facility making a written request thereof, 2) that all the information contained herein is true and correct and that if anything contained herein is false, LocumTenens.com may immediately terminate any contract entered into with applicant, and 3) that applicant shall notify LocumTenens.com in writing if any of the answers or information contained herein becomes incorrect or incomplete.

Typed or Printed Signature of Date
Name of Physician Physician

DISCLOSURE STATEMENT

LocumTenens.com discloses to you that a consumer report and/or investigative consumer report may be obtained for independent contractor screening purposes as part of the credentialing process and at any time during your association with the Company as an independent contractor. An investigative consumer report may include information as to your character, general reputation, personal characteristics and mode of living, whichever apply. The Fair Credit Reporting Act provides you with the right to request, in writing within a reasonable amount of time, a disclosure of the nature and scope of the investigation requested. You may also request a written summary of your rights under the Fair Credit Reporting Act as prepared by the Federal Trade Commission.

APPLICANT CONSENT FORM TO RELEASE INFORMATION

I understand that in consideration of my application to associate as an independent contractor with LocumTenens.com, an investigation may be conducted of my past employment and activities. I authorize past employers, personal references and any other persons with whom I am acquainted to answer all questions asked concerning my previous employment record, ability, character, educational background, military service and credit history. I release all persons, including past employers, credit bureaus, and government agencies from any liabilities or damages for having furnished such information.

In consideration of my application to associate as an independent contractor with LocumTenens.com, I hereby authorize the Company and/or its agents to conduct such an investigation, and release all agents, including their officers, employees, agents and representatives from all liability or responsibility for this investigation, which may include, but is not limited to, the gathering of information regarding personal, professional and educational references, credit or consumer investigations, driving histories, civil, professional license and any criminal history information which may be in the files of any state, local or federal criminal justice agency. I understand that the information requested regarding date of birth, race and sex is for the sole purpose of gathering the above information accurately, and will not be used to discriminate against me in violation of any law. A telephonic facsimile (fax) or a photographic copy of this authorization shall be as valid as the original.

LocumTenens.com and its employees and representatives, are hereby authorized to obtain an investigative consumer report and consult with the employees and medical staff members of any medical facility with which I have ever been associated and with such other individuals or organizations including, but not limited to, past and present insurance malpractice carriers, state medical boards of which I have been a member, private practitioners, hospitals with which I have been associated, and medical schools I have attended, and/or any other persons, organizations and/or associations in order to obtain information bearing on my academic record, work record, personal character and professional performance or other relevant evaluations.

In consideration of the furnishing of the above information, I hereby release and discharge LocumTenens.com and its employees and all representatives and any other individuals or organizations providing such information, and any and all persons, employees, representatives or agents of any of the above from any and all liability or claims of any nature in connection with the information furnished to LocumTenens.com. I further consent to the release of information obtained through a background investigation to LocumTenens.com client hospitals, clinics, and health care providers. I understand that it may be difficult to obtain the background information unless it is solicited in a confidential manner. I understand and agree that I will not have access to this information and I waive any right of access to this information that I may have under the laws of any state of the United States, except as may be required by court order. A copy of this Authorization and Release may be provided to each individual hospital or organization where information on my credentials is sought and shall remain in effect until specifically revoked in writing by me.

Typed or Printed Signature of Date
Name of Physician Physician

# LOCUM TENENS PRACTICE EXPERIENCE

List professional locum tenens experience in chronological order. Attach a separate sheet if necessary.

1. Facility \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Contact \_\_\_\_\_ Date from \_\_\_\_\_ To \_\_\_\_\_

2. Facility \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Contact \_\_\_\_\_ Date from \_\_\_\_\_ To \_\_\_\_\_

3. Facility \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Contact \_\_\_\_\_ Date from \_\_\_\_\_ To \_\_\_\_\_

4. Facility \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Contact \_\_\_\_\_ Date from \_\_\_\_\_ To \_\_\_\_\_

5. Facility \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Contact \_\_\_\_\_ Date from \_\_\_\_\_ To \_\_\_\_\_

6. Facility \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Contact \_\_\_\_\_ Date from \_\_\_\_\_ To \_\_\_\_\_

7. Facility \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Contact \_\_\_\_\_ Date from \_\_\_\_\_ To \_\_\_\_\_

List Hospital(s) where you were privileged \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Administrator \_\_\_\_\_ Date from \_\_\_\_\_ To \_\_\_\_\_

## ANESTHESIA EVALUATION OF CLINICAL SKILLS

Please check each of the boxes below in which you are currently skilled.

- |  |   |
|--|---|
| <input type="checkbox"/> General inhalational anesthesia   | <input type="checkbox"/> Minor regional anesthesia including:                           |
| <input type="checkbox"/> General intravenous anesthesia  | <input type="checkbox"/> Selective minor nerve blocks (wrist, ankle, digital)           |
| <input type="checkbox"/> Anesthesia subspecialty including:  | <input type="checkbox"/> Intravenous regional anesthesia                                |
| <input type="checkbox"/> Cardiac   | <input type="checkbox"/> Sympathetic nerve blocks:                                      |
| <input type="checkbox"/> OB/GYN  | <input type="checkbox"/> Stellate ganglion  |
| <input type="checkbox"/> Pain  | <input type="checkbox"/> Lumbar sympathetic   |
| <input type="checkbox"/> Chronic pain evaluation, including diagnostic and therapeutic procedures  | <input type="checkbox"/> Monitored anesthesia care                                      |
| <input type="checkbox"/> Acute pain consultation and management including the use of continuous intravenous, epidural, and intraspinal analgesics. | <input type="checkbox"/> Hypothermic anesthesia techniques                              |
| <input type="checkbox"/> ICU   | <input type="checkbox"/> Hypotensive anesthesia techniques                              |
| <input type="checkbox"/> Major Vascular  | <input type="checkbox"/> Resuscitation (including emergency drug therapy)               |
| <input type="checkbox"/> Thoracic  | <input type="checkbox"/> Fiberoptic laryngoscopy  |
| <input type="checkbox"/> Major regional anesthesia including:  | <input type="checkbox"/> Invasive monitoring techniques including:                      |
| <input type="checkbox"/> Subarachnoid anesthesia (spinal)  | <input type="checkbox"/> Arterial lines   |
| <input type="checkbox"/> Caudal anesthesia   | <input type="checkbox"/> Central venous pressure lines                                  |
| <input type="checkbox"/> Thoracic epidural   | <input type="checkbox"/> Pulmonary artery catheters                                     |
| <input type="checkbox"/> Lumbar epidural   | <input type="checkbox"/> Ventilator management in the post-op or intensive care setting |
| <input type="checkbox"/> Cervical epidural   | <input type="checkbox"/> Respiratory therapy consultation and/or supervision            |
| <input type="checkbox"/> Selective major nerve blocks including:   | <input type="checkbox"/> Pre-operative anesthetic consultations                         |
| <input type="checkbox"/> Axillary  | <input type="checkbox"/> Post-operative anesthetic consultations                        |
| <input type="checkbox"/> Interscalene  | <input type="checkbox"/> Post-operative evaluation/assessment                           |
| <input type="checkbox"/> Femoral   | <input type="checkbox"/> Pediatric assessment   |
| <input type="checkbox"/> Sciatic   | <input type="checkbox"/> Neo-natal anesthesia   |
|  | <input type="checkbox"/> Airway management  |
|  | <input type="checkbox"/> Muscle relaxation management                                   |

Signature of Physician \_\_\_\_\_ Date \_\_\_\_\_

# LocumTenens.com

## 2009 TIMESHEET SCHEDULE

<b>If you worked from:</b>	<b>Timesheet MUST be received by 6:00 p.m. EST:</b>		<b>Your pay date is:</b>	
December 15-December 28	Monday	December 29	Friday	January 9
December 29 January 11	<b>Monday</b>	<b>January 12</b>	Friday	January 23
January 12– January 25	Monday	January 26	Friday	February 6
January 26 –February 8	Monday	February 9	Friday	February 20
February 9– February 22	Monday	February 23	Friday	March 6
February 23– March 8	Monday	March 9	Friday	March 20
March 9– March 22	Monday	March 23	Friday	April 3
March 23– April 5	Monday	April 6	Friday	April 17
April 6– April 19	Monday	April 20	Friday	May 1
April 20– May 3	Monday	May 4	Friday	May 15
May 4– May 17	Monday	May 18	Friday	May 29
May 18– May 31	Monday	June 1	Friday	June 12
June 1– June 14	Monday	June 15	Friday	June 26
June 15– June 28	Monday	June 29	Friday	July 10
June 29 - July 12	Monday	July 13	Friday	July 24
July 13 – July 26	Monday	July 27	Friday	August 7
July 27 – August 9	Monday	August 10	Friday	August 21
August 10 – August 23	Monday	August 24	Friday	September 4
August 24 – September 6	Monday	September 7	Friday	September 18
September 7 – September 20	Monday	September 21	Friday	October 2
September 21 – October 4	Monday	October 5	Friday	October 16
October 5 – October 18	Monday	October 19	Friday	October 30
October 19 – November 1	Monday	November 2	Friday	November 13
November 2 – November 15	Monday	November 16	Friday	November 27
November 16 – November 29	Monday	November 30	Friday	December 11
November 30 – December 13	Monday	December 14	Friday	December 25

- *Monday deadline is extended until Tuesday for Providers working in facilities closed due to Government holidays.*
- *All timesheets must be signed and approved by the Client.*
- *If you miss the deadline, you will be paid on next pay period.*

**Direct Deposit: Funds are deposited to your account the Monday following payroll.**

# AUTHORIZATION AGREEMENT FOR ACH CREDITS (DIRECT DEPOSIT)

\_\_\_\_\_  
INDIVIDUAL NAME

\_\_\_\_\_  
ID NUMBER

(Company Tax ID or SSN)

I (WE) hereby authorize LocumTenens.com herein after called Individual, to initiate credit entries and/or correction entries to our  *Checking*  *Savings account (select one)* indicated below at the depository named below, herein called DEPOSITORY, to credit the same such account. I acknowledge that the origination of the ACH transactions to my account must comply with the provisions of the U.S. law.

\_\_\_\_\_  
**DEPOSITORY NAME**

\_\_\_\_\_  
**BRANCH**

\_\_\_\_\_  
**CITY**

\_\_\_\_\_  
**STATE**

\_\_\_\_\_  
**BANK TRANSIT/ABA NUMBER**

(aka "routing number")

\_\_\_\_\_  
**ACCOUNT NUMBER**

This authorization is to remain in full force until the Individual has received written notification from me (or either of us) of its termination in such time and in such manner as to afford Individual and DEPOSITORY reasonable opportunity to act upon it.

\_\_\_\_\_  
NAME(S)

\_\_\_\_\_  
TAX ID NUMBER (or SSN)

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**

**Please fax completed copy to 678-352-4351**

After we receive your completed form, a prenote will be sent to your bank. Afterwards, we must wait six business days to allow time for your bank to validate your account information and get back to us if problems are encountered. Please keep this time frame in mind when anticipating your first direct deposit. If you have any questions concerning whether or not your check will be paper vs. electronic, please call us to verify.

**Funds are deposited to your account the Tuesday following payroll. This Tuesday disbursement allows for bank processing time. Payment information is sent to the bank on Friday, but the bank must have two business days for processing transactions.**

**Request for Taxpayer  
Identification Number and Certification**

Give form to the  
requester. Do not  
send to the IRS.

Print or type  
See Specific Instructions on page 2.

Name (as shown on your income tax return)	
Business name, if different from above	
Check appropriate box: <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ ..... <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
City, state, and ZIP code	
List account number(s) here (optional)	

**Part I Taxpayer Identification Number (TIN)**

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 2. For other entities, it is your employer identification number (EIN). If you do not have a number, see How to get a TIN on back.

Social security number								
<table border="1" style="width:100%; height: 20px;"> <tr> <td style="width: 15%;"> </td> <td style="width: 15%;"> </td> <td style="width: 15%;"> </td> <td style="width: 15%;"> </td> <td style="width: 15%;"> </td> <td style="width: 15%;"> </td> <td style="width: 15%;"> </td> <td style="width: 15%;"> </td> </tr> </table>								
or								
Employee identification number								
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**Note:** If the account is in more than one name, see the chart on back for guidelines on whose number to enter.

**Part II Certification**

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
- I am a U.S. citizen or other U.S. person (defined below).

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments, other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN.

<b>Sign Here</b>	Signature of U.S. person ▶	Date ▶
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**Purpose of Form**

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

- Certify that the TIN you are giving is correct (or you are waiting for a number to be issued).
- Certify that you are not subject to backup withholding, or
- Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

**Note:** If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Forms W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- ▶ The U.S. owner of a disregarded entity and not the entity,
- ▶ The U.S. grantor or other owner of a grantor trust and not the trust, and
- ▶ The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

**Foreign person.** If you are a foreign person do not use Form W-9. Instead, use the appropriate Form W-8 (see Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

**Specific Instructions**

**Name**  
If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

**Sole proprietor.** Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business trade, or "doing business as (DBA)" name on the "Business name" line.

**Limited liability company (LLC).** Check the "Limited liability company" box only and enter the appropriate code for the tax classification ("D" for disregarded entity, "C" for corporation, "P" for partnership) in the space provided.