PHYSICIAN REFERRAL REWARD PROGRAM
SUBMISSION FORM

Name of person submitting the candidate referral:

Name: _____

Address: _____
Street City State Zip

Current Date: _____ Phone: _____

E-mail address: _____

SMGSI Employee: _____ Yes _____ No Work Location: _____

Physician Information

Name: _____

Home Phone: _____ Cell Phone: _____

E-mail address: _____

Referring physician for: _____
Specialty Location

Resume/Curriculum Vitae Attached: _____Yes _____ No

Candidate submission approved for referral reward: _____ Yes _____ No

If no, reason for ineligibility: _____

For Physician Recruitment Use

Reward Amount Approved $ _____ Notified date/initials: _____

_____ _____
Signature 1st Approval Date

_____ _____
Signature 2nd Approval Date

For Human Resources' Use

Physician Candidate Start Date: _____

Complete 6 months of employment: $2,500 1st pmt due: _____ Paid date: _____

Complete 12 months of employment: $2,500 2nd pmt due: Paid date: