PART TIME SUPPLEMENT

If you are practicing 20 hours a week or less and you request a part-time discount, please complete this supplemental application.

-Please answer all questions. Do not leave any blanks. If a question is not applicable, write "N/A".
-The application must be signed and dated by the applicant.

1. Name (First, Middle, Last): ____ ☐ MD ☐ DO
2. **DD/MM/YY** you began a semi-retired or limited practice: ______/______/______
3. Are you disabled? ☐ Yes ☐ No **If yes, please explain your disability and submit medical documentation.**

   ____

4. Please list your office hours for each day of the week: ______________________________________
5. Do you supervise or have any of the following providing professional services on your behalf?

				IF YES, HOW MANY?	**IF YES**, HOW MANY ***TOTAL*** **HOURS PER WEEK** DO THEY WORK?
a.	ARNP	☐ Yes	☐ No	________	________________
b.	CNM/LM	☐ Yes	☐ No	________	________________
c.	CRNA	☐ Yes	☐ No	________	________________
d.	PA-C	☐ Yes	☐ No	________	________________

6. Provide total number of ***hours per week*** you devote to the following aspects of your practice:
   - a. _____ Actual patient care
   - b. _____ Actual patient record keeping
   - c. _____ Administrative duties for your practice
   - d. _____ After hours emergency care
   - e. _____ Hospital rounds
   - f. _____ Returning patients' calls (including after hours)

7. Provide a detailed explanation regarding your part-time practice status:

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The above statements are, to the best of my knowledge, the truth and I have not knowingly withheld any information which is calculated to influence the judgment of the Company in considering this application.

Signature: ___________________________________ **Date**: ______________________________

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