Nicole Denmark, DVM

Denmark Veterinary Relief Services, PLLC

dvm.nicole.denmark@gmail.com

586-322-8030

Date:

Practice Owner/Manager:

Clinic Name:

Address:

_____,

Thank you for contacting me for veterinary relief services. I have reserved the following dates to work at your clinic:

- _____
- _____
- _____

Species treated:

I will receive your canine and feline patients presented to me during the above scheduled hours and I will work outside of those hours as I deem necessary to treat patients under my care, schedule permitting.

Services:

I will perform all routine veterinary medical services as needed for your hospital and patients unless they are outside of my clinical skill set in which case I will offer a referral. I am comfortable with all routine wellness exams, basic urgent care cases, chronic illness cases, basic abdominal and cardiac ultrasonography, as well as triage and stabilization of emergency cases. For our mutual benefit, I will not perform any surgical procedures excluding basic laceration repairs and dermal biopsies providing the

hospital has appropriate sedation protocols and appropriate monitoring for sedated patients.

Billing rate:

- My billing rate is ___/8 hour shift or 25% of production whichever is the higher number.
- My billing rate is ___/10 hour shift or 25% of production whichever is the higher number.
- Billing rate for half day is ___/4 hour shift or 25% of production, whichever is the higher number.
- I reserve the right to bill __/daily for any clinics that are more than 15 miles from my home.

Payment:

- Invoices will be sent to the clinic every 14 days.
- Invoices are expected to be paid in full within 14 days of invoice date.
- Invoices not paid in full within 14 days of invoice date will incur a 2 percent late fee applied every 14 days overdue.

Licensing/Insurance/Exemptions:

Please note for your records that I am an independent contractor. I carry my own health, liability, and disability insurance. If I earn more than 600 dollars this year while working with you, you will need to file a 1099 with my name. Please note, in the state of Virginia, I am not required to carry workers' compensation insurance. I will provide my certificate of exemption.

- VA state license: 0301206361
- NC state license: 6252
- DEA license number will be provided on a as needed basis.
- I have PLIT liability coverage

Cancellation Policy:

If you need to cancel this engagement for any reason, you will be billed as follows:

- Cancellation greater than 30 days from the agreed upon work date will not incur a fee.
- Cancellations less than 30 days but greater than 14 days from the agreed upon work date will incur a bill of 50% of the daily rate.
- Cancellations 14 days or less from the agreed upon work date will incur a bill for the full daily rate.
- Cancellations due to weather related state of emergencies where the hospital needs to close or other catastrophic events that prevent the hospital from opening will not incur a penalty.
- In the unlikely event that I need to cancel a shift with less than 14 days notice from the scheduled work date, I will offer to work a future date at 50% of the hourly rate for the same hourly shift.
- In the unlikely event that either party finds the work shift to be unsatisfactory, the dissatisfied party will inform the other party in writing that they wish to terminate any future shifts booked.
    - If the shifts are cancelled more than 30 days prior to the agreed upon work date no cancellation fee will be applied.
    - If the shifts are cancelled less than 30 days and greater than 14 days prior to the agreed upon work date, the hospital will incur a bill of 50% of the daily rate unless I am able to rebook the shift.
    - If shifts are cancelled 14 days or less than the agreed upon work date the hospital will incur a bill for the full daily rate unless I am able to rebook the shift.

Please sign below stating you understand the terms of this agreement.

Hospital representative signature: _____

_____ Nicole Denmark, DVM