IOWA ASSOCIATION MEDICAL STAFF SERVICES

Forms Manual

1) IAMSS Expense Reimbursement Report
2) IAMSS Speaker Agreement
3) IAMSS New Member Form
4) IAMSS Renewal Membership Form
5) IAMSS Conference Sponsorship Contract
**IOWA ASSOCIATION MEDICAL STAFF SERVICES**  
**EXPENSE REIMBURSEMENT REPORT**

Expenses Incurred By: ____________________________________________________________

Address: __________________________ City ______________ State ______ Zip Code __________

Purpose: _______________________________________________________________________

Dates __________________________________________________________________________

**DETAILED Receipts are required – Please attach**

<table>
<thead>
<tr>
<th>TYPE OF EXPENSE</th>
<th>DATE</th>
<th>DATE</th>
<th>DATE</th>
<th>DATE</th>
<th>DATE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meals (not to exceed $30/day)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Itemized meal receipts per day</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Lodging</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Hotel</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Travel</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Airfare</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Car Rental</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Ground Transportation (Taxi, Uber, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Parking</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Misc- Specify below *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Seminar Presentation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Mileage Reimbursement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

**Date**

<table>
<thead>
<tr>
<th>Travel To/From</th>
<th>Mileage</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Mileage: _______________ $0.58/mile $ _______________

**Totals**

| $ | $ | $ | $ | $ | $ | $ |

*Explanation of Meals for Others and Misc.: _______________________________________________

**PLEASE NOTE: ALL RECEIPTS MUST BE TURNED IN WITHIN 90 DAYS FROM THE DATE OF THE EVENT.**

I certify that I am familiar with the provisions of IAMSS’ Expense Statement and Travel Policy and that this expense statement is accurate as to actual and necessary business expense.

**SIGNATURE** ____________________ **DATE** ____________

---

Revised 9/21/2018  
Submit to: Melinda Wheeler, CPCS, IAMSS Treasurer  
MAIL: Mahaska Health Partnership, 1229 C Avenue East, Oskaloosa, Iowa 52577
I, ____________________________, agree to speak at the Iowa Association Medical Staff Services Conference to be held at _____________________________ in _____________________________. The date(s), time(s) and topic(s) of my presentation(s) are:

Date: _____________________________  Time: _____________________________
Topic: ______________________________

I agree to forward a curriculum vitae and outline on my topic one month prior to the conference to be able to plan for the CEU’s for and handouts at least one week prior to the date of the conference. I agree that I will bear the cost and responsibility of making copies of my outline and handouts if I do not meet this deadline. I agree to turn in all expense receipts within ninety (90) days of the scheduled event to the IAMSS Treasurer.

In return for my services as speaker, IAMSS has agreed to pay $_________, reasonable travel expenses, hotel accommodations and food (please see explanation below).

**Hotel:** IAMSS will provide accommodation for one night only*. Incidental expenses are the speaker's responsibility. (*Adjustment made for those speakers presenting more than one day or for all-day speakers who may not be able to obtain a flight out the same day.)

**Travel:** Airfare to Des Moines, Iowa, and return trip for speaker only. Transportation from airport to hotel: IAMSS will reimburse speaker for mileage at current IRS rate or for cost of rental car.

**Reasonable Travel Expenses:** Estimated travel costs should be forwarded to IAMSS no later than one month before engagement. Should the cost of travel be unreasonable, IAMSS reserves the right to negotiate your travel costs. IAMSS reserves the right to work with travel agent to find reasonable airfares.

**Food:** IAMSS agrees to pay up to $30 per day for meals.

I agree to the terms listed above. I understand the terms will not be modified unless approved by the President of IAMSS.

______________________________  _____________________________
Speaker Signature  Date

______________________________  _____________________________
IAMSS Representative  Date
IOWA ASSOCIATION MEDICAL STAFF SERVICES
NEW MEMBER FORM

Name: _______________________________ Date: ______________

Job Title: _____________________________________________

Facility: ______________________________________________

Street Address: _________________________________________

City/State/Zip: __________________________________________

Work Number: __________________ Fax Number: ____________

Email Address: _________________________________________

Accredited by (check any that apply):

☐ TJC  ☐ DNV  ☐ NCQA  ☐ State Surveyed Only
☐ URAC  ☐ Other: Specify_______________________________
☐ Not applicable

Best describes your role/setting: (check all that apply)

☐ Medical Staff Credentialing
☐ Critical Access Hospital / Hospital (Bed size:________)
☐ CVO  ☐ Practitioner Clinic / Office
☐ Managed Care  ☐ Provider Enrollment
☐ Other: Specify_____________________________________

Credentialing Software Used (if applicable): ____________________________

NAMSS Member ☐ Yes ☐ No

Certified Provider Credentialing Specialist (CPCS) ☐ Yes ☐ No

Certified Professional Medical Services Management (CPMSM) ☐ Yes ☐ No

Checks should be made payable to Iowa Association Medical Staff Services. Membership dues are $50. The IAMSS membership year is January 1—December 31. Membership dues received after October 1 will be applied to the next membership year. Please return your completed application and check to the IAMSS Treasurer:

Melinda Wheeler, CPCS
Mahaska Health Partnership
1229 C Avenue East
Oskaloosa, Iowa 52577
Ph: 641.672.3388  Fx: 641.672.3336
Email: mwheeler@mahaskahealth.org

Revised 09/2018
IOWA ASSOCIATION MEDICAL STAFF SERVICES
RENEWAL MEMBERSHIP FORM

☐ NO CHANGES NEEDED (Complete name, date and facility only)

Name: ___________________________ Date: ___________________________

Job Title: ___________________________

Facility: ___________________________

Street Address: ___________________________

City/State/Zip: ___________________________

Work Number: ___________________________ Fax Number: ___________________________

Email Address: ___________________________

Accredited by (check any that apply): ☐ TJC ☐ DNV
☐ NCQA ☐ State Surveyed Only
☐ URAC ☐ Other: Specify_____________________
☐ Not applicable

Best describes your role/setting: ☐ Medical Staff Credentialing
☐ Critical Access Hospital / Hospital (Bed size:__________)
☐ CVO ☐ Practitioner Clinic / Office
☐ Managed Care ☐ Provider Enrollment
☐ Other: Specify_____________________

Credentialing Software Used (if applicable): ___________________________

NAMSS Member ☐ Yes ☐ No

Certified Provider Credentialing Specialist (CPCS) ☐ Yes ☐ No

Certified Professional Medical Services Management (CPMSM) ☐ Yes ☐ No

Checks should be made payable to Iowa Association Medical Staff Services. Membership dues are $50. The IAMSS membership year is January 1—December 31. Membership dues received after October 1 will be applied to the next membership year. Please return your completed application and check to the IAMSS Treasurer:

Melinda Wheeler, CPCS
Mahaska Health Partnership
1229 C Avenue East
Oskaloosa, Iowa 52577
Ph: 641.672.3388 Fx: 641.672.3336
Email: mwheeler@mahaskahealth.org

Revised 09/2018
IOWA ASSOCIATION MEDICAL STAFF SERVICES
CONFERENCE SPONSORSHIP CONTRACT

We, ______________________________, hereby make application for sponsorship as indicated below for the Iowa Association Medical Staff Services conference to be held at __________________________ on __________________________.

Sponsorship opportunities are as follows:

_____ On-Site Exhibitor | (Includes company logo on all signage and one 6-foot table for display. Requires $250 sponsorship, token member gifts [200 pc].

_____ Conference Sponsor | (Includes company logo on all signage. Requires $100 sponsorship, token member gifts [200 pc], and any company materials the sponsor wishes to have distributed to attendees.)

_____ IAMSS Supporter | (Requires door prize valued at >$25)

It is understood and agreed that all tabletop space will be assigned on a first come/first serve basis and that the Program Coordinator reserves the right to assign exhibitors to the best alternate space and to make reasonable shifts in location for the benefit of the exhibitor and for the conference attendees.

Display tables may remain in place from 7:00 a.m. the morning of the conference through the last break of the day. IAMSS members will be available for interaction each day before the conference, during 2 morning breaks, a lunch break, and an afternoon break.

No space will be guaranteed until IAMSS receives full payment of the total fee and a signed contract. If payment is not received 30 days prior to the conference date, IAMSS will have the right to re-sell the assigned space. No refunds for cancellations will be made after ___________________

Please email a company logo to: Rhonda Meyers at rhonda.meyers@unitypoint.org no later than four (4) weeks prior to the conference. (Please type or print all information)

Firm: __________________________________________________________

Name: ____________________________ Title: ____________________________

Address: ________________________________________________________

City: ____________________________ State: __________ Zip Code: __________

Phone #: (__________)________________ Fax #: (__________)______________

Email: ______________________________

---

Vendor Signature ______________________ Date ________________

IAMSS Representative __________________________ Date ______________

Please complete this form and return with your check made payable to: Iowa Association Medical Staff Services Conference Sponsor fee and all additional materials and token member gifts can be shipped to this address.

UnityPoint Health – St. Luke’s | Rhonda Meyers | 2720 Stone Park Blvd. | Sioux City, IA  51104

Revised 09/2018
IOWA ASSOCIATION MEDICAL STAFF SERVICES
SCHOLARSHIP APPLICATION

Name: ___________________________ Date: ______________

Job Title: ____________________________________________

Facility: ______________________________________________

Street Address: _________________________________________

City/State/Zip: __________________________________________

Work Number: ______________________ Fax Number: ______________

Email Address: __________________________________________

________________________________________________________________

IAMSS Member ☐ Yes ☐ No

________________________________________________________________

☐ I am responsible for my own conference fees

☐ My organization is unable to fund my conference fees due to budgetary restraints

Application and personal essay/statement should be mailed or emailed to:

Melinda Wheeler, CPCs
Mahaska Health Partnership
1229 C Avenue East
Oskaloosa, Iowa 52577
Ph: 641.672.3388 Fax: 641.672.3336
Email: mwheeler@mahaskahealth.org

All scholarship applications received prior to the application deadline of November 15th will be considered, and notice of decision will be sent by December 31st for the Annual Meeting scheduled for the next calendar year.