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
6) IAMSS Scholarship Application
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 $30/day)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>$</td>
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<tr>
<td>Itemized meal receipts per day</td>
<td></td>
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<td>$</td>
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<tr>
<td>Lodging</td>
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<td>$</td>
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<tr>
<td>Hotel</td>
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<tr>
<td>Travel</td>
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<td>$</td>
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<tr>
<td>Airfare</td>
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<tr>
<td>Car Rental</td>
<td></td>
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<tr>
<td>Ground Transportation (Taxi, Uber, etc.)</td>
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<tr>
<td>Parking</td>
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<td>$</td>
</tr>
<tr>
<td>Misc- Specify below *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
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<tr>
<td>Seminar Presentation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Mileage Reimbursement</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td>$</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Travel To/From</th>
<th>Mileage</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</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 10/7/2019

Submit to: Pat Probasco, IAMSS Treasurer
MAIL: MercyOne Centerville Medical Center, One St. Joseph’s Dr., Centerville, IA 52544
IOWA ASSOCIATION MEDICAL STAFF SERVICES
SPEAKER AGREEMENT

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

Revised 9/2018
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:

☐ 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:

Pat Probasco
MercyOne Centerville Medical Center
One St. Joseph’s Drive
Centerville, IA  52544
Ph: 641.437.3411  Fx: 641.437.3304
Email: PProbasco@mercydesmoines.org

Revised 10/7/2019
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

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Revised 10/7/2019
IOWA ASSOCIATION MEDICAL STAFF SERVICES
CONFERENCE SPONSORSHIP CONTRACT

We, ____________________________________________, hereby make application for sponsorship as indicated
(Company Name)
below for the Iowa Association Medical Staff Services conference to be held at ________________________________
on _________________.
(Location; City) (Date)

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 10/7/2019
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:

Pat Probasco
MercyOne Centerville Medical Center
One St. Joseph’s Drive
Centerville, IA  52544
Ph: 641.437.3411   Fax: 641.437.3304
Email: PProbasco@mercydesmoines.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.

Revised 10/7/2019