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

TYPE OF EXPENSE	DATE / /	DATE / /	DATE / /	DATE / /	DATE / /	DATE / /	TOTAL
Meals (not to exceed $40/day)							
Itemized meal receipts per day							$
Lodging							
Hotel							$
Travel							
Airfare							$
Car Rental							$
Ground Transportation (Taxi, Uber, etc.)							$
Parking							$
Misc- Specify below *							
							$
							$
							$
Seminar Presentation							
							$
Mileage Reimbursement							

Date	Travel To/From	Mileage	Remarks
	Total Mileage:	0	**$0.65.5/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**

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 $40 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

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Checks should be made payable to **Iowa Association Medical Staff Services**. Membership dues are $60. 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

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:
(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

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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

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_____,
(Location; City)
on_____.
(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: Julie Dunham at JDunham@missioncancer.com 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

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 90 days prior to the educational conference will be considered, and notice of decision will be provided 45 days prior to the conference.