



Physician Assistant Referral Service (PARS)

Dear Healthcare Provider:

The IAPA has a Referral Service that you may wish to consider when you are ready to accept employment applications. This program has a 90% placement rate.

I have enclosed information on the Illinois Academy of Physician Assistant's Referral Service (PARS). You complete the form and return to the IAPA office. Over 600 listings will be distributed to licensed members PAs and students. Any non-members inquiring about the PARS program will also be sent a copy.

COST: \$600
TERMS: Three month computer listing
RENEWABLE: \$100 per additional month

IAPA will present a draft of your listing for approval. Then your completed form will be mailed to all members and added at the IAPA website within one week. In addition to the one time mailing mentioned above, anyone calling for job information will be sent current listings.

INSTRUCTIONS: Complete the attached PARS form and return it with your check payable to IAPA. We also accept credit cards. Remember to complete both pages of the form and print or type to insure accuracy. Since you have selected the PARS program, you have targeted your search to a direct and specific market. We think you will be satisfied with the results.

Sincerely,
Kari Anderson
IAPA Executive Director

Credit Card Authorization: I hereby give "Association Management Partners, Inc." the authority to process my credit card in the amount of \$ _____ for the PA Referral Service.

Credit Card Number: _____

Name on the Card: _____ Expiration Date: _____

Signature: _____



Physician Assistant Referral Service (PARS)

Please complete and return the form below with your check to the address below. Please list one specialty per form.

Number of Positions per Specialty: _____

Specialty: (Place a #1 in your primary specialty and #2 in your secondary specialty.)

- | | | |
|--------------------------------------------------|--------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Anesthesiology | <input type="checkbox"/> Other | <input type="checkbox"/> Allergy |
| <input type="checkbox"/> Anesthesiology | <input type="checkbox"/> Neurology | <input type="checkbox"/> Public Health/Pref. Ed |
| <input type="checkbox"/> Dermatology | <input type="checkbox"/> BO/Gin | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> Emergency Medicine | <input type="checkbox"/> Ophthalmology | <input type="checkbox"/> General Surgery |
| <input type="checkbox"/> Family/General Practice | <input type="checkbox"/> Orthopedics | <i>Surgical Subspecialties</i> |
| <input type="checkbox"/> Geriatrics | <input type="checkbox"/> Otolaryngology | <input type="checkbox"/> Cardiovascular |
| <input type="checkbox"/> Gen. Int. Medicine | <input type="checkbox"/> Pathology | <input type="checkbox"/> Colon and Rectal |
| <i>Internal Medical Subspecialties</i> | <input type="checkbox"/> General Pediatrics | <input type="checkbox"/> Hand |
| <input type="checkbox"/> Cardiovascular Disease | <i>Pediatric Subspecialties</i> | <input type="checkbox"/> Neurological |
| <input type="checkbox"/> Critical Care | <input type="checkbox"/> Allergy | <input type="checkbox"/> Pediatric |
| <input type="checkbox"/> Endocrinology | <input type="checkbox"/> Cardiology | <input type="checkbox"/> Plastic |
| <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> Endocrinology | <input type="checkbox"/> Thoracic |
| <input type="checkbox"/> Hematology/Immunology | <input type="checkbox"/> Hematology/Oncology | <input type="checkbox"/> Traumatic |
| <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Nephrology | <input type="checkbox"/> Urological |
| <input type="checkbox"/> Nephrology | <input type="checkbox"/> Neurology | <input type="checkbox"/> Vascular |
| <input type="checkbox"/> Pulmonary | <input type="checkbox"/> Pulmonary | Other: _____ |
| <input type="checkbox"/> Rheumatology | <input type="checkbox"/> Physical Medicine/Rehab | Other: _____ |

Practice Location: (please circle one)

Rural

Urban

HPSA

Setting: (check one:)

- | | | |
|------------------------------------------------|------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Solo Office Practice | <input type="checkbox"/> Hospital/Public | <input type="checkbox"/> Inner city/Clinic/Hospital |
| <input type="checkbox"/> Group Office Practice | <input type="checkbox"/> Clinic/Public | <input type="checkbox"/> Military/Clinic/Hospital |
| <input type="checkbox"/> Jail/Prison | <input type="checkbox"/> Clinic/Private | <input type="checkbox"/> Other Clinical |
| <input type="checkbox"/> HMO | <input type="checkbox"/> Nursing Home | <input type="checkbox"/> Other: Non-Clinical |
| <input type="checkbox"/> Hospital/Private | <input type="checkbox"/> Rural Clinic/Hospital | |

Malpractice Coverage:

- No Malpractice Insurance
- Rider on Employer's Policy
- Employer self insures
- Other: _____

Hours: (Please circle) Full time: Y N Part Time: Y N Weekends: Y N Call: Y N

Salary Arrangement: (Check One)

Straight Salary _____
Salary plus % of revenues _____
Salary plus Productivity Bonus _____

Salary Range: (Check One)

Part Time: Under \$25,000 _____ \$25,000 - \$35,000 _____ \$35,000 - \$45,000 _____ Over \$45,000 _____

Full Time* \$65,000 - \$75,000 _____ \$75,000 - \$85,000 _____ Over \$85,000 _____

* 2006 Census shows the median salary for a PA in Illinois with more than 2 years experience is \$77,341.00.

Application Requirements: (Check where applicable)

Resume/Curriculum Vitae _____ Letters of Recommendation _____

If interest in the above position, please mail _____ fax _____ email _____ and/or call _____:

First Name: _____ MI: _____ Last Name: _____

Office Name: _____

Office Address: _____

Office City: _____ Office State: _____ Office Zip: _____

Office Telephone: _____ Office Fax: _____

E-Mail: _____

The information below this line will not be reproduced. Please indicate the name, address and phone of the individual providing this information for the PARS program if different from the name above.

First Name: _____ MI: _____ Last Name: _____

Office Name: _____

Office Address: _____

Office City: _____ Office State: _____ Office Zip: _____

Office Telephone: _____ Office Fax: _____

I understand that this placement request will be circulated to all Physician Assistants who are members and non-members of the Illinois Academy of Physician Assistants.

Signature: _____ Date: _____

Send by check to 225 East Cook Street, Springfield IL 62704 or fill out information with credit card and fax back to 217-789-4664.