SOADI Circle of Care Service Provider Agreement

First Name: Last Name:		Phone number:
Mailing Address: City:		Postal Code:
Name of Company or Place of Employment:		Contact number:
Mailing Address *if different*: City:		Postal Code:
Professional Affiliation:		Registration Number: Expiry Date:
Insurance Company:		Insurance number: Expiry Date:
Email:		SOADI Registration number:

_____ Initial

I _____, acknowledge that I read and adhere to SOADI's Circle of Care Program Guidelines (policy and procedures); and agree to SOADI's mission, vision and mandate. Pg 3

_____ Initial

I have provided a copy of my registration with and good standing with my professional affiliations (please list below). I have provided my resume and other relevant information including proof of liability insurance and certifications. Pg. 5

_____ Initial

I adhere to the standards and practice within the Province of Ontario, Canada and appropriate bodies of governance. Pg. 5

_____ Initial

I acknowledge that becoming registered with SOADI; I give consent for my contact information to be in the published SOADI Circle of Care Directory; I give consent for photographs taken of me at SOADI events to be used in publications. Pg. 4

_____ Initial

I acknowledge that I am an Independent Contractor and am responsible for submitting all taxes and government deductions. I accept and agree to the rate schedule including travel stipulations. Pg. 17, appendix 2

_____ Initial

I acknowledge that I am responsible for patient screening, assessment, treatment, and documentation and follow up; ensuring adherence to the collection of information follows the Privacy Act. Pg. 10

_____ Initial

I acknowledge that invoices are required directly after SOADI Circle of Care Clinics, annual and ongoing. Individual Subsidies are required to be submitted once a month on a summary invoice form (form II.B.3 & 4). Pg. 17

_____ Initial

I acknowledge that I am responsible for all supplies for sustainable clinics and subsidy assessments. I acknowledge my responsibilities of SOADI Circle of Care Clinic Events. Pg. 3-13

_____ Initial

I give permission and consent to disclose any information to relevant and appropriate parties upon request.

_____ date _____ _____ date _____

Contractor's signature Witness signature

_____ date _____

Per Southern Ontario Aboriginal Diabetes Initiative
Signature

SOADI Head Office
83250 Schmon Parkway, Unit 1B, Thorold On, L2V 4Y6
Tel:1 888 514 1370 · Fax: 1-866-352-0485
Web: www.soadi.ca