



### SOADI Foot 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 <i>if different</i> :	City:	Postal Code:
Professional Affiliation:	Registration Number:	Expiry Date:
Insurance Company:	Insurance number:	Expiry Date:
Email:	SOADI Registration number:	

\_\_\_\_\_ I \_\_\_\_\_, acknowledge that I read and adhere to SOADI's Foot 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 Foot 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. 14, 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. 9  
 \_\_\_\_\_ Initial

\_\_\_\_\_ I acknowledge that invoices are required directly after SOADI Foot 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. 14  
 \_\_\_\_\_ Initial

\_\_\_\_\_ I acknowledge that I am responsible for all supplies for sustainable clinics and subsidy assessments. I acknowledge my responsibilities of SOADI Foot Care Clinic Events. Pg. 3, 10.  
 \_\_\_\_\_ Initial

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

\_\_\_\_\_ date \_\_\_\_\_ date  
 Contractor's signature Witness signature

\_\_\_\_\_ date \_\_\_\_\_  
 Per Southern Ontario Aboriginal Diabetes Initiative  
 Signature

SOADI HEAD OFFICE  
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