



Adirondack Staffing Solutions

113 Saratoga Rd, Ste 208, Glenville, NY 12302

Ph (518)982-0062 Fax (518)982-0072

Frequent Cancellation Agreement

Exhibit C

Adirondack Staffing Solutions, LLC greatly values your business and works diligently to bring you the services upon your request. Unfortunately, due to the frequency of cancellations we must present and obtain a signed copy of this document in order to maintain a positive working relationship. Placing your requests on our calendar, spreading the word thorough our community, and booking candidates has its fair share of administrative involvement. We would like to be certain that any request from your practice is taken as seriously on your end as it is on our end. Please read and agree to the following:

I understand that in the event that I, or any of my office affiliates, cancel any placement of a temporary candidate, that has been requested through your agency, there will be a \$10.00 nonrefundable charge for each placement cancellation date to the credit/debit card I have provided below. This will be charged within 24-72 hours once cancellation is received.

Furthermore, I understand that in the event of a request for temporary candidate through your agency, for any coverage of 10 days or more, within a 30-day period, there will be a \$25.00 administrative fee, that will be charged to the credit/debit card I have provided below. This will be applied to the Agency's placement fee in the event that at least 50% of the dates requested are *not* cancelled by my office or any of its affiliates.

I authorize Adirondack Staffing Solutions, LLC to retain my credit/debit card information and to automatically charge my account in the event that my practice is unable to keep a scheduled temp request, as stated above and/or in the event that 10 days or more of temporary coverage is requested. Furthermore, I understand that this agreement does not take the place of the cancellation policy as outlined in the "Dental Office Information & Agreement" signed upon contracting business with the Agency. I understand that I will receive said invoice receipts, via email, once the credit/debit card has been charged pertaining to this agreement.

Practice Name _____

Cardholder Name _____

Credit/Debit Card # _____ Exp Date _____ CVV _____

Cardholder address _____

City

State

Zip code

Cardholder Signature _____