**5/03/19**

**PAID SECONDARY ASSIGNMENTS OFFER LETTER TEMPLATE**

*(****Full Name***)

(***Address***)

(***City, State, Zip***)

Dear (***Dr. /Mr. /Ms****.):*

I am pleased to offer you a secondary assignment as (*academic title*) in the Department of *(name of department/division)*, at (*Name of School*)**.** (*Name of School*) is a part of Rutgers Biomedical and Health Sciences of Rutgers, the State University of New Jersey (“University”).

This is a secondary assignment in addition to your primary appointment in the (department) at (*primary school*).

This secondary assignment is for a term, beginning on or about (*date*) and ending on (*date, if applicable*). This appointment is an at-will appointment. At the expiration of this assignment, reappointment may or may not be offered.

**FOR CLASS 4:** You will be paid $(*hourly rate*) for (*statement of detailed duties/responsibilities – include day(s) of week, hours per day/week. etc.).* Your annual academic base salary should not exceed $\_\_\_\_\_\_\_\_\_\_\_\_\_\_. This annual salary is based on (*describe how annual salary was calculated; number of hours worked per week/month, etc*.). You will be paid via the Extra Pay Time & Labor process in PeopleSoft. My department Time & Labor Preparer will work with your primary department’s Time & Labor Preparer to report all secondary assignment hours worked (*PeopleSoft Code, “Extra Hours”).*

**FOR CLASS 8**: You will be paid $(*course rate*) for teaching (*statement of detailed course being taught – include day(s) of week, hours per day/week. etc*.).

***If clinical faculty:*** Your receipt and maintenance of (1) a full, unconditional and unrestricted license to practice medicine or dentistry in the State of New Jersey, and (2) valid registrations from the U.S. Drug Enforcement Administration (“DEA”) and the New Jersey Office of the Attorney General, Division of Consumer Affairs, Drug Control Unit (“CDS”) are conditions of your employment with the University. You certify that you have not in the past and are not currently a “sanctioned individual” as defined in 42 U.S.C. Sec. 1320a-7(b)(8), regarding individuals excluded from participation in Medicare or any state Medicaid program. **[State any additional requirements for board certification, credentialing, and/or enrollment in Medicaid and Medicare Programs.]** If you do not obtaina valid New Jersey clinical license and DEA and CDS registrations (state any other requirements) within 90 days of your start date, or for such period of time as extended by the Dean, your appointment will be terminated.  **[State any requirement to maintain hospital privileges at (name of hospital)].** It is your responsibility to immediately notify your Chair upon any non-renewal, suspension or termination of a full, unconditional and unrestricted license and/or any required registrations. You must also notify your Supervisor immediately upon notice that you are under investigation for any claim which could lead to exclusion from participation in Medicare or any state Medicaid program or which could subject you to sanctions by the New Jersey Board of Medical Examiners or New Jersey Board of Dentistry. If you fail to maintain your license and/or any required registrations in full, unconditional and unrestricted status (or in the event that certain conditions or restrictions are placed on your license), or you are excluded from participation in Medicare or any state Medicaid program you will be immediately removed from any patient care activities. Compensation may be suspended or reduced if you are unable to perform employment responsibilities as a result of a failure to maintain your license and/or any required registrations (or as a result of conditions or restrictions being placed on your license), or if you are excluded from participation in Medicare or any state Medicaid program. In addition, failure to maintain a full, unconditional and unrestricted license and/or any required registrations, or if you become excluded from participation in Medicare or any state Medicaid program, shall constitute a breach of the terms and conditions of this Agreement, and may result in a termination of the employment relationship.

***If clinical faculty:*** You are required to participate in the Medicare and Medicaid Programs as well as other commercial health plans and third-party payor programs as may be determined by Rutgers in its sole discretion. You must ensure that your services are provided in accordance with requirements of the Medicare and Medicaid Programs and of such commercial health plans and third-party payors.

You may indicate your acceptance of the terms and conditions of this Letter of Offer by signing in the space provided below and return to me as soon as possible.

Sincerely yours,

Department Chair Name \_\_\_\_\_\_\_\_\_\_

Chair, Department of Date

(*Name*) \_\_\_\_\_\_\_\_\_\_

Dean Date

*Agreed to by:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Faculty Name Date