Pre-application for Medical Staff Privileges: Allied Health Provider

Return the completed pre-application to Floyd Medical Staff Office by fax 706-509-6901 or email medstaff@floyd.org.

Select all facilities you are requesting privileges to:

Floyd Medical Center __________ Polk Medical Center ___________ Floyd Primary Care ___________

Last Name_________________ First Name __________________ Middle____________ Title________

GA State License Number _____________ Expiration______________ Date of Birth ______________

NPI Number: __________________________ Medical/Professional School _________________________

Date of Graduation_________________

Office Address ____

City____ State ____________ Zip ____________________

Office Phone ______________________ Office Fax ______________________

E-Mail address (Personal) _________________________________

Name of Sponsoring/Supervising Physician ____

Name of Office Contact or Practice Manager ____

Email Address or Contact Phone____

To appoint a delegate to enter data and submit documents through the Floyd application portal complete the delegate authorization below.

Residence Address ____

City ____ State ______________ Zip___________________

Residence Telephone ____

Please indicate your clinical specialty____

I certify that I meet the prerequisites for receiving an application. I understand that the information requested on this pre-application questionnaire is sought to enable the hospital to make an administrative determination as to whether I am eligible to receive an application. This pre-application questionnaire does not constitute an application.

I hereby release from any and all liability, and agree not to sue, the hospital and its representatives for their actions in connection with evaluating the information provided on this questionnaire and determining whether or not I am eligible to receive an application. I understand that a determination that I am ineligible to receive an application does not give rise to any hearing rights under the Medical Staff By-Laws.

________________ ____

Date Print Name

____

Signature

Provider’s Authorization for Delegate

The individual listed below is my delegate. I hereby authorize (hereinafter, individually referred to as “Delegate”) to access the Floyd Medical Center web portal to enter data and submit documents for appointment and reappointment consideration on my behalf. I understand that I will need to review the data and documents and attest to their accuracy before I submit them to the entity via the Floyd Medical Center web portal.

Delegate information is for Floyd Medical Center online credentialing only. No other correspondence will be redirected based on information provided in this section.

Name:_____________________________________

Email:_____________________________________

Phone: ____________________________________

Please complete, sign and date. Return the completed pre-application to Floyd Medical Staff Office by fax 706-509-6901 or email medstaff@floyd.org.

I acknowledge that I have voluntarily provided the above information, and I have carefully read and understand this Authorization. I understand and agree that a facsimile or photocopy of this Authorization shall be as effective as the original.

___________________________________	___________________________________
Provider Signature	Print Name
___________________________________	___________________________________
Full NPI Number	Date