Atrium Health Floyd

NON-EMPLOYED PROVIDER INFORMATION FORM (PIF)

Please return completed PIF along with provider's CV to medstaffFloyd@atriumhealth.org

Date Submitted to Medical Staff:
Anticipated Date for clinical Privileges:

Provider Information				
Last Name	**Middle Name**	**First Name**	**Title (Credentials)**	
SSN	**DOB**	**NPI**	**Male**	**Female**
			☐	☐

Current Home Address		**City, State, Zip**
Phone	**Alternate Phone**	**Preferred Email** Alternate Email
Practicing Specialty:		

Practice/Group Information		
Primary Practice/Group:		
Practice/Group Address:		City, State, Zip:
Practice/Group Phone:	Secure Fax:	**Clinical Start Date:**
Credentialing Contact **NAME**:		Credentialing Contact **EMAIL:**

SELECT PRIVILEGE LOCATIONS – *Indicate **Primary Privileges Location here** if more than one location is checked:* _____

Privilege Locations:	**Telemedicine Only:**
☐ Atrium Health Floyd	☐ Atrium Health Floyd
☐ Atrium Health Floyd Polk	☐ Atrium Health Floyd Polk
☐ Atrium Health Floyd Cherokee	☐ Atrium Health Floyd Cherokee
☐ Floyd Primary Care	☐ Floyd Primary Care

Additional Comments
Notes/Comments:

PHYSICIAN or PHYSICIAN ASSISTANT

Georgia Medical License	DEA (GA)	Alabama Medical License	DEA (AL)	Taxonomy

ADVANCED PRACTICE PROVIDER - Enter Sponsoring Physician Name:

GALicense	DEA (GA)	AL License	DEA (AL)

Please complete and forward the completed PIF along with the provider's CV to **medstaffFloyd@atriumhealth.org**