

**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	
SSN	DOB	NPI		Title (Credentials)
				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 <i>Primary Privileges Location here</i> if more than one location is checked: _____				
Privilege Locations: ☐ Atrium Health Floyd ☐ Atrium Health Floyd Polk ☐ Atrium Health Floyd Cherokee ☐ Floyd Primary Care			Telemedicine Only: ☐ Atrium Health Floyd ☐ Atrium Health Floyd Polk ☐ Atrium Health Floyd Cherokee ☐ 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)

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