

Atrium Health

New Provider Information Form (PIF)

Community / Affiliate

(Please complete ***electronically*** and forward the completed PIF along with the provider’s current CV **to** [MSSproviderREQ@atriumhealth.org](mailto:MSSproviderREQ@atriumhealth.org))

Date of Submission: Click or tap to enter a date.  **Physician**  **Advanced Practice Provider**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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 Information | | | | | | | | |
| Primary Practice: | | | | | | | | |
| Practice Address: | | | | | | | City, State, Zip: | |
| Practice Phone: | | | | SecureFax: | | | **Clinical Start Date:** | |
| Practice Manager/Contact **NAME**: | | | | | Practice Manager/Contact **EMAIL:** | | | |
| Privilege Information | | | | | | | | |
| **Start Date:       Canopy Date:** | | | | | | **Canopy Course Type:**  **Acute (Hospital)  Anesthesia**  **Emergency Medicine  Ambulatory (Practice)** | | |
| **SELECT PRIVILEGE LOCATIONS** *– Indicate* ***Primary Privileges Location here*** *if more than one location is checked:* | | | | | | | | |
| CMC/Mercy **\*\*INDICATE if**:  CMC-Randolph and/or  CMC-Davidson | | Anson  Cabarrus  Carolinas Rehabilitation  Cleveland/Kings Mountain  Lincoln | | | | Pineville  Stanly  Union/Union West Hospital University | | CMC Harrisburg ED  CMC Huntersville ED  CMC Kannapolis ED  CMC SouthPark ED  CMC Steele Creek ED  CMC Providence ED  CMC Waxhaw ED |
| **Select Telemedicine Only Locations here:** | | | | | | | | |
| CMC**/**Mercy | | Anson  Cabarrus  Carolinas Rehabilitation | | | | Cleveland/Kings Mountain  Lincoln  Pineville | | Stanly  Union/Union West Hospital  University |
| **Other Telemedicine Only Locations** | | | | | | | | |
| Training Status (PHYSICIAN ONLY) | | | | | | | | |
| From Residency/Fellowship | | | **Incoming Fellow? Yes  No** | | | |  | |
| Additional Comments | | | | | | | | |
| **Notes/Comments:** | | | | | | | | |

**PHYSICIAN or PHYSICIAN ASSISTANT**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| NC State Medical License | DEA (NC) | SC Medical License | DEA (SC) | Taxonomy |
|  |  |  |  |  |

**ADVANCED PRACTICE PROVIDER -** EnterSponsoring Physician Name:

|  |  |  |  |
| --- | --- | --- | --- |
| **NC Approval to Practice License** | **DEA (NC)** | **SC Approval to Practice License** | **DEA (SC)** |
|  |  |  |  |

**REGISTERED NURSE**

|  |  |  |  |
| --- | --- | --- | --- |
| **NC Registered Nurse Licensure** | **OTHER STATE RN** | **OTHER STATE RN** |  |
|  |  |  |  |

Please complete *electronically* and forward the completed PIF along with the provider’s current CV **to** [MSSproviderREQ@atriumhealth.org](mailto:MSSproviderREQ@atriumhealth.org)