

Atrium Health

Provider Information Form (PIF)

Physician and Dentist Support Staff

**Date of Submission**:

|  |
| --- |
| Provider Information |
| **Full Legal Name:** **[ ] M [ ] F** | **SSN:**  | **DOB:****Place of Birth:** | **NPI:** |
| Current Address:  | City, State, Zip:  |
| Cell Phone:  | Alternate Phone:  | Preferred Email: Alternate Email**:** |
| **Practicing Specialty:** |  |  |
| Title | Practicing Setting |
| **[ ]** Audiologist**[ ]** Physician Rounder**[ ]** Social Worker**[ ]** Dental Assistant**[ ]** Registered Nurse**[ ]** Surgical Scrub Nurse**[ ]** Physical Therapist**[ ]** Scribe**[ ]** Surgical Technician**[ ]** Patient Experience Coordinator**[ ]** Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **[ ]** Behavioral Health**[ ]** Cardiology**[ ]** Critical Care**[ ]** Emergency Department**[ ]** Hematology/Oncology**[ ]** Hospice/Palliative Care**[ ]** Medical/Surgical**[ ]** Neurology**[ ]** Operating Room**[ ]** Pediatrics**[ ]** Women’s Center**[ ]** Other**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Practice Information |
| Primary Practice:  |
| Practice Address | City, State, Zip:  |
| Practice Phone: SecureFax: | **Start Date**:   |
| Practice Manager/Contact: **Phone: Email**: |
| **Sponsoring/Supervising Physician Full Name:**  |
| Hospital Location Information |
| **Primary location (if more than one location checked):****Anticipated Atrium Access Date:****[ ]  Indicate if Emergency Medicine Provider (includes Behavioral Health ED providers)**  |
| **Hospital Locations you are applying for:** [ ]  CMC/Mercy [ ]  AH Pineville [ ]  AH University City [ ]  AH Union/Union West [ ]  AH Lincoln[ ]  AH Cabarrus [ ]  AH Cleveland/Kings Mountain [ ]  AH Stanly [ ]  AH Anson[ ]  Carolinas Rehabilitation Main [ ]  Carolinas Rehab-Mt. Holly [ ]  Carolinas Rehab–NorthEast[ ]  AH Surgery Center Indian Train [ ]  AH Surgery Center Shelby [ ]  Center for Orthopaedic Surgery (Rock Hill, SC) |

Please complete electronically and forward the completed PIF along with the provider’s current Resume/CVto

**MSSproviderREQ@AtriumHealth.org**



Atrium Health

Physician and Dentist Support Staff Checklist

Thank you for choosing Atrium Health! Below are the required documents that you will need to submit to complete the Physician/Dentist Support Staff application process. If at any time you need assistance, please contact the Medical Staff Services office at (704) 355-2147.

**Complete application & supporting documents must be returned within 10 business days.**

* Enlarged, color copy of current state driver’s license, government ID, or military ID
* Resume: Mandatory items listed on your resume should include: complete history for the last seven (7) years Support Staff has lived, worked, gone to School - include city, state, and an explanation of all gaps in time during this seven (7) year time period.
* Negative 12-panel Drug Screen (must be done *independently* and dated within 30-60 days of anticipated access/start date)
* Copy of current license/certification to practice in North Carolina
* Copy of license/certification to practice in any other state
* Copy of highest level of education diploma
* Flu vaccine once Flu Season is declared at Atrium Health (September 1 through March 31st)
	+ For Flu Exemption requests, please email TeammateHealthFluInfo@atriumhealth.org
* TB/PPD (Less than 1 year old)
* Varicella, MMR & Hep B vaccines or titers
* Covid vaccine(s)
* Completed Competency form – will be emailed to applicant
* Sterling background check – will be emailed to applicant
* Color photo for ID badge – please use a professional photo with solid background
* Facility orientation if entering an Atrium Health operating room
* Copies of professional training certificates (e.g. surgical technologist, dental assistant, etc.)
* Certificate of Insurance reflecting Atrium Health as the certificate holder and the applicant’s

name listed under the Physician/Dentist sponsor in the amount of no less than $1,000,000 per occurrence and $3,000,000 aggregate.

* Legible Copy of Visa/Work Authorization documentation, if applicable.
* Signed BLS Card, if applicable for discipline requested - (Only American Heart Association cards will be accepted and category must read “Healthcare Provider “ or “BLS Provider”. BLS card cannot expire within 90 days of application submission; Must be signed by the card holder; Must have instructor name and number listed. Roster or letter of class attendance will not be accepted.

**Please email completed items to your Credentialing Specialist as they become available.**