

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](mailto: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](mailto: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.**