



**AFFILIATED PROFESSIONAL PRE-APPLICATION**

**Enclosed is the REQUEST FOR APPLICATION for  
Affiliated Professional Clinical Functions at Northside Hospital**

**Please note that this is NOT the application.  
Complete the enclosed materials and return the packet to  
Medical Staff Services at the address listed below.  
Please keep a copy for your records.**

Northside Hospital  
Medical Staff Services – Dept 944  
Attn: Takeisha Cundiff  
975 Johnson Ferry Rd NE, Suite 550  
Atlanta, GA 30342  
Phone: 404-851-8743  
Fax: 404-250-7330  
Email: [APapplicationrequest@northside.com](mailto:APapplicationrequest@northside.com)

**Once these documents have been returned to Medical Staff Services, and  
evaluated for eligibility criteria, application materials will be sent to you.**

Please return within 3 days to ensure timely processing of your application request



## NORTHSIDE HOSPITAL

### REQUEST FOR AFFILIATED PROFESSIONAL APPLICATION

**PERSONAL INFORMATION:**

Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

NPI #: \_\_\_\_\_ Email: \_\_\_\_\_

**1. I am requesting Clinical Functions in the following category:**

☐ **Dependent\*** Affiliated Professional Clinical Functions of a: *(select one)*

- ☐ Physician Assistant (PA) ☐ Anesthesia Assistant (AA)
- ☐ Nurse Practitioner (NP) ☐ Certified Registered Nurse Anesthetist (CRNA)
- ☐ Certified Nurse-Midwives (CNM) ☐ Registered Nurse\* (RN) ☐ Licensed Practical Nurse\* (LPN)
- ☐ Surgical Assistant\* ☐ Surgical Tech\* ☐ Pathology Assistant\* ☐ Medical Assistant\*
- ☐ Membership Only – *no clinical functions at any Northside Hospital or Outpatient Facility*

My Physician Sponsor is: \_\_\_\_\_ Specialty: \_\_\_\_\_

*Northside requires all Dependent Affiliated Professionals to be sponsored by a physician with medical staff privileges*

*\*Medical Staff credentials these positions only if not directly employed by Northside Hospital*

☐ **Independent\*** Affiliated Professional Clinical Functions of a: *(select one)*

- ☐ Psychologist ☐ Optometrist ☐ Dietitian

**2. I am requesting Clinical Functions at the following Northside Hospital campus(es)**

- ☐ Atlanta ☐ Cherokee ☐ Duluth ☐ Forsyth ☐ Gwinnett

**3. To which address should your application be sent? Please indicate address in the space below.**

Attention: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Email: \_\_\_\_\_

**4. Practice Information:**

Name of group/practice: \_\_\_\_\_

Primary office address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Anticipated start date: \_\_\_\_\_

5. **License Information:**

Georgia License Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

- ☐ If **PA or AA**, I confirm that my Northside Sponsoring Physician is recorded with Georgia Composite Medical Board (GCMB) as my Supervising Physician and a Job Description has been filed. **OR** I confirm that paperwork has been filed to update my Supervising Physician with GCMB and update my Job Description.

Note: Clinical Functions will not be granted until Sponsoring Physician and Job Description are approved by GCMB

- ☐ If **APRN (ex. NP, CRNA, CNM)**, I confirm that I have a current Nurse Protocol Agreement with my Northside Sponsoring Physician. **OR** I confirm that I am in process of creating a Nurse Protocol Agreement with by Sponsoring Physician.

Note: Clinical Functions will not be granted until a current Nurse Protocol Agreement is shared with Medical Staff Services

6. **Certification Information:**

National Certifying Board: \_\_\_\_\_

Certification Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

7. **Insurance Information\*:**

\*Insurance Information is not required for staff directly employed by Northside Hospital

Insurer: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

All Affiliated Professionals, as a condition to obtaining or maintaining clinical privileges or clinical functions, shall carry a minimum of (\$1,000,000) one million dollars of malpractice insurance coverage

**Please send me a full application for Affiliated Professional privileges at Northside Hospital**

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

## Medical Staff Services Preapplication and Application Process

