NORTHSIDE HOSPITAL

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

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: PROVIDERS_LONGNAME Cell Phone: _____

Social Security #: _____ Date of Birth: PROVIDERS_DATEOFBIRTH

NPI #: PROVIDERS_NPI Email: PROVIDERS_CONTACTEMAILADDRESS

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: PROVIDERS_LONGNAME

Street Address: _____

City, State, Zip: _____

Email: PROVIDERS_CONTACTEMAILADDRESS

4. **Practice Information:**

Name of group/practice: ASSIGNMENTS_ACTIVE_ADDRESSES_GROUPNAME1_1

Primary office address: ASSIGNMENTS_ACTIVE_ADDRESSES_ADDRESSLINE21_1

City, State, Zip: ASSIGNMENTS_ACTIVE_ADDRESSES_CITY1_1, ASSIGNMENTS_ACTIVE_ADDRESSES_STATE1_1, ASSIGNMENTS_ACTIVE_ADDRESSES_ZIPCODE1_1

Anticipated start date: _____

5. **License Information:**

Georgia License Number: LICENSES_STATE_LICENSES_LICENSENUMBER _____ Expiration Date: LICENSES_STATE_LICENSES_EXPIRATIONDATE _____

☐ **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: BOARDS_CERTIFIED_BOARD_RTK1 _____

Certification Number: _____ Expiration Date: _____

7. **Insurance Information*:**

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

Insurer: KAISER FOUNDATION _____

Policy Number: SELF INSURED _____ 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**

NORTHSIDE HOSPITAL

Medical Staff Services Preapplication and Application Process