EMORY
HEALTHCARE

REQUEST FOR APP APPLICATION
ADVANCED PRACTICE PROFESSIONAL

PLEASE TYPE OR PRINT, FILL IN ALL SECTIONS, INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED

Name: Providers_LongName) Date: [CURRENT DATE]
Printed or Typed Name

Specialty: (i.e. Medicine, Surgery…..) ProviderSpecialties_Specialty_RTK Sub-Specialty: _____

Sponsoring Physician: _____

I hereby apply:

X [DEFAULT]	To practice at *Emory Decatur Hospital* Application Fee $100
_____	To practice at *Emory Long-Term Acute Care* Application Fee $100
_____	To practice at *Emory Hillandale Hospital* Application Fee $100
_____	All of the above - Application Fee $250

I am seeking to practice/participate as: PROVIDERS_DISPLAYDEGREES_SHORT
(Indicate profession)

Please Return To:

Sheronda Davis
sheronda.davis@emoryhealthcare,org

GENERAL INFORMATION: **Please complete all of the requested information listed below**

Name: Providers_LongName)

Maiden Name (*if applicable*): Providers_OtherName_Last

Home Address: _____

City/State/Zip: _____

Home Telephone : Providers_ContactCellPhone Pager : _____

Business: The Southeast Permanente Medical Group [DEFAULT]

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

Office Telephone : 404-365-0966 [DEFAULT] Fax : _____

Email Address: PROVIDERS_CONTACTEMAILADDRESS

Marital Status: PROVIDERS_MARITALSTATUS_RTK Name of Spouse: _____

Date of Birth: PROVIDERS_DATEOFBIRTH Place of Birth: Providers_PlaceOfBirth

Citizenship: Providers_Citizenship M/F: Providers_Sex

Social Security : _____

Are you legally eligible to work in the United States: YES_____ NO _____

Georgia Medicaid Enrollment Attestation

Effective May 14, 2018, section 2.A.1.o the medical staff credentialing policy states one of the qualifications for being on the medical staff is for physicians and mid-level providers is:

(o) Must be enrolled in the Georgia Medicaid Program either as a participating provider accepting patients or as an Ordering, Prescribing or Referring (OPR) Provider for integrity purposes. Any individual who does not satisfy this requirement may submit a written request to the Chief Executive Officer for the requirement to be waived. No individual is entitled to a waiver, nor is any individual entitled to the hearing procedures described in this Policy in the event the Board determines not to grant a waiver.

I Providers_LongName)_____ (print name) acknowledge the following:

- Medicaid enrollment is required
- Lack of current Medicaid enrollment will not delay the approval of my pre-application
- Submission of this form is required. Failure to submit this form will delay approval of your completed full application.
- My current status with Medicaid enrollment is (please check all that apply)

☐ I am currently enrolled with GA Medicaid as a participating provider or as an ordering, prescribing or referring provider (OPR). My GA Medicaid registration ID number is: _____

☐ I am currently not enrolled; I have applied to GA Medicaid. Application submittal date is: _____. I understand that final application approval for medical staff membership will not be approved until enrollment is complete and verified by the medical staff services office.

☑ I am currently not enrolled and plan to enroll. I understand that final application approval for medical staff membership will not be approved until enrollment is complete and verified by the medical staff services office.

☐ I wish to request a waiver of the requirement: Must give reason for requesting the waiver. All waivers must be approved by the Board of Directors. If requesting a waiver, pre-application will not be approved until the Board has made a decision on this request.

_____

_____

_____

_____

Applicant signature: _____ Date: _____

SUBJECT: Meaningful Use Stage 3

In preparation for Meaningful Use Stage 3 we will be implementing two important initiatives; Secure Health Messaging (SHM) in the Allscripts application, and an electronically exchanged Summary of Care Document (also referred to as a Continuity of Care Document). These initiatives are both required for DeKalb Medical to achieve Meaningful Use. We would like to make all applicants aware of what will be required for each member of the medical staff, including Advance Practice Providers.

To implement these initiatives, each provider will need three email addresses. The first email address will be for use by medical staff services office to send general communications to the medical staff. The second email address will be used for SHM. The third email address will be used to send the Summary of Care. The email address used for general communications and SHM can be the same email address.

The SHM email will be used for the following:

- *to register you in SureScripts – the medication/pharmacy health information exchange used by SCM*
- *to permit use of new SCM functionality that will allow you to send electronic 'Cancel' messages to pharmacies*
- *to allow you to send and receive Secure Health Messaging notifications*
- *Please note, If you are an employed provider, your DeKalb Medical Email will be used for SHM.*

It is important to note the SHM email will be available to any registered user in SureScripts, including pharmacy vendors. The SHM email will be used to share clinical information about the care of your patients. In addition, DeKalb staff will have access to this email address from within any Sunrise application. Once an email is registered with Surescripts, it cannot be removed from the database.

Please complete the attached form and submit with your pre-application or application packet.

Thank you in advance for your attention to this request.

Provider Email Address

Provider Name: Providers_LongName)

Medical Staff Services: Please use the following email address(s) for medical staff communication:

PROVIDERS_CONTACTEMAILADDRESS

(Please type or print legibly)

Secure Health Messaging (SHM):

You **can use** the same email as used for Medical Staff Services (above)

Please note: for Emory Healthcare employed providers, your Emory Healthcare Email will be used for SMH. Please contact your office manager for assistance in obtaining your Emory email address. The IT department will provide a "_@emoryhealthcare.org email address within one week of notification.

Use the following email address for **SHM**:

Pending Kaiser email address [DEFAULT]

(Please type or print legibly)