Provider Pre-Screening Form

☐ **Primary Care** ☐ **Specialty Care**

Provider Information

Full Name: _____ Degree: _____

SSN: _____ Gender: _____ DOB:_____ License #: _____

City of Birth: _____

Practicing Specialty: _____

Have you previously applied for membership with Affinity Medical Group?

☐ Yes ☐ No If yes, please provide date: _____

Board Certifications

Primary Board Certification: _____ Expiration Date: _____

If Board eligible, when did you complete your residency or fellowship?

Date: _____ Intent Certification Date: _____

Sub-Specialty Board Certification: _____ Expiration Date: _____

If Board eligible, when did you complete your residency or fellowship?

Date: _____Intent Certification Date: _____

Practice Information

☐ **Solo Practice** ☐ **Group Practice** *(Please provide a participating provider roster)*

Group: _____ Provider Name: _____

Primary Office Address: _____

Office Phone: _____ Office Fax: _____

Tax ID: _____ Languages: _____

Other IPA: _____

_____

On Call Group / MD (must be an Affinity contracted provider within your same specialty):

_____

Referred by an AMG contract provider? If so, who?

_____

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Hospital and ASC Privileges *(Please list all Hospitals with whom you hold privileges)*

Facility & City: _____ Privileges: _____

Facility & City: _____ Privileges: _____

Facility & City: _____ Privileges: _____

Facility & City: _____ Privileges: _____

Facility & City: _____ Privileges: _____

Physician Owned Distributorship (POD)

If you are part of a POD or receive revenue from a POD, please provide details of your relationship with the said POD) below:

☐ Yes ☐ No

_____

_____

_____

Contact Information

Name of Person Facilitating this Request: _____

Title / Position: _____ Email: _____

Phone: _____ Fax: _____

Physician Signature: _____ **Date:** _____