Affinity Medical Group
Membership Request Form

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

Provider Information

Full Name: _____ Degree: _____

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

City and State of Birth: _____

Practicing Specialty: _____

Provider Email Address: _____

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: _____

Do you use an EMR? ☐ No ☐ Yes (*If Yes, which Electronic Medical Record system is used at your facility?)*

_____

Practice Information

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

Group: _____ Provider Name: _____

Primary Office Address: _____

Office Phone: _____ Office Fax: _____

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Please indicate the percentage of time spent by the requesting Provider at the primary office location: ☐ **80%** ☐ **90%** ☐ **100%**

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? _____

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

☐ Yes ☐ No

_____

_____

_____

Name of Person Facilitating this Request: _____

Title / Position: _____ Email: _____

Phone: _____ Fax: _____

Please fax this completed form along with all supporting documents to Provider Network Operations at (650) 497-6898.

Physician Signature: _____ **Date:** _____