Pre-application for Medical Staff Privileges: Physician, Dentist, Oral surgeon or Podiatrist

Return the completed pre-application to Floyd Medical Staff Office by fax 706-509-6901 or email medstaff@floyd.org.

Select all facilities you are requesting privileges to:

Floyd Medical Center: _____ Polk Medical Center: _____ Floyd Primary Care: _____

Last Name:_____ First Name: _____ Middle:_____ Title:_____

GA State License Number: _____ Expiration:_____ Date of Birth: _____

NPI Number: _____

Medical/Professional School: _____ Date of Graduation:_____

Office Address: _____

City: _____ State: _____ Zip: _____

Office Phone: _____ Office Fax: _____

Email address (Personal):_____

Name of Office Contact or Practice Manager:_____

Email Address or Contact Phone Number: _____

To appoint a delegate to enter data and submit documents through the Floyd application portal complete the delegate authorization form below.

Residence Address: _____

City: _____ State: _____ Zip:_____

Residence Telephone: _____

Please indicate the Medical Staff category to which appointment is desired.

___ **Active**. The active medical staff may regularly admit patients to the hospital and shall have all the functions and responsibilities of membership on the active medical staff, including where appropriate, emergency service care, outpatient clinic care and consultation assignments. Members of the active medical staff shall be appointed to a specific department, shall be eligible to vote at meetings of the medical staff, to hold office on the medical staff and to serve on medical staff committees and shall be required to attend medical staff meetings.

___ **Emergency Room**. The emergency room medical staff shall consist of those physicians who have entered into a contract with the governing body for the purpose of treating patients in the emergency room. They may not vote or hold office on the medical staff. They may admit a patient only to the service of an active medical staff member.

___ **Consulting**. The consulting staff category is limited to those physicians and dentists whose primary office and place of practice is located outside of Floyd County, Georgia and who, in the judgment of the executive committee,

possess expertise or experience not possessed by any member of the active medical staff and which would be of possible benefit to patients of the hospital. Consulting medical staff members shall not be eligible to admit patients, shall not vote or hold office on the medical staff nor shall they have any other privileges granted by the medical staff bylaws or by the governing body to the active medical staff but shall be authorized to see patients in consultation with members of the active medical staff. Notwithstanding the foregoing, hospital-based neonatologists who are granted consulting staff status shall have the privilege to admit neonatal patients to the hospital and to serve as the infant's attending physician.

___ **Telemedicine**. Membership in this category is limited to those physicians and dentists whose primary office and place of practice is located more than 30 air miles from the hospital and who wish to be privileged to provide telemedicine services for the benefit of hospital patients when requested by a medical staff member serving as the patient's attending or consulting physician. As used herein, "telemedicine" means the practice of medicine through the use of electronic communication which involves the provision of clinical care to a hospital patient at a distance. As used in the preceding sentence, "the practice of medicine" means any contact that results in a written or documented medical opinion and affects the medical diagnosis or medical treatment of a hospital patient.

Telemedicine practitioners shall be considered members of the medical staff and shall be appointed to a specific clinical department. They shall not be eligible to admit patients or to vote or hold office on the medical staff. They shall be authorized to render telemedicine services to a hospital patient only at the request of and in consultation with a medical staff member serving as the patient's attending or consulting physician. Members of the telemedicine practitioner category are exempt from all meeting attendance requirements set forth in the medical staff bylaws.

___ **Floyd Primary Care Office-Based**. Practice is limited to providing patient care in an office setting.

Please indicate your clinical specialty as well as any procedures or privileges outside of that specialty area that you would like to request:

Floyd Medical Center

Medicine	**Select (X)**	**Surgery**	**Select (X)**	**Other Specialty**	**Select (X)**
Allergy/Immunology		Cardio-Thoracic		Anesthesiology	
Cardiology		General Dentistry		ER Medicine	
Dermatology		General Surgery		Family Medicine	
Endocrinology		Neurosurgery		Hospitalist – IM	
Gastroenterology		Ophthalmology		Hospitalist – FM	
Hematology/Oncology		Oral Surgery		OB/GYN - Gynecology only	
Infectious Disease		Orthopaedics		Pathology	
Internal Medicine		Otolaryngology		Pediatrics - Neonatology	
Nephrology		Pediatric Dentistry		Psychiatry	
Neurology		Plastic Surgery		Radiation Oncology	
Physical Med & Rehab		Podiatry		Radiology, Diagnostic	
Pulmonology		Urology			
Rheumatology		Vascular			

Polk Medical Center

Medicine	Select (X)	Surgery	Select (X)	Other Specialty	Select (X)
Allergy/Immunology		General Dentistry		Anesthesiology	
Cardiology		Ophthalmology		ER Medicine	
Dermatology		Oral Surgery		Family Medicine	
Endocrinology		Orthopaedics		Pathology	
Gastroenterology		Podiatry		Pediatrics	
Hematology/Oncology		Pediatric Dentistry		Psychiatry	
Infectious Disease				Radiology, Diagnostic	
Internal Medicine					
Nephrology					
Neurology					
Physical Med & Rehab					
Pulmonology					
Rheumatology					

Floyd Primary Care

Office Based	Select (X)	Moonlighting	Select (X)
Family Medicine		Emergency Medicine	
Internal Medicine		Family Medicine	
Pediatrics		Internal Medicine	
		Pediatrics	

Procedures or other privileges outside of your specialty area that you would like to request: _____
_____

Do you plan to establish or have you established an office near the hospital? ____Yes ____ No

If yes, where? _____

I certify that I meet the prerequisites for receiving an application. I understand that the information requested on this pre-application questionnaire is sought to enable the hospital to make an administrative determination as to whether I am eligible to receive an application. This pre-application questionnaire does not constitute an application.

I hereby release from any and all liability, and agree not to sue, the hospital and its representatives for their actions in connection with evaluating the information provided on this questionnaire and determining whether or not I am eligible to receive an application. I understand that a determination that I am ineligible to receive an application does not give rise to any hearing rights under the Medical Staff By-Laws.

Date: _____ Print Name: _____

Signature: _____

Provider's Authorization for Delegate

The individual listed below is my delegate. I hereby authorize (hereinafter, individually referred to as "Delegate") to access the Floyd Medical Center web portal to enter data and submit documents for appointment and reappointment consideration on my behalf. I understand that I will need to review the data and documents and attest to their accuracy before I submit them to the entity via the Floyd Medical Center web portal.

Delegate information is for Floyd Medical Center online credentialing only. No other correspondence will be redirected based on information provided in this section.

Name:_____

Email:_____

Phone: _____

Please complete, sign and date. Return the completed pre-application to Floyd Medical Staff Office by fax 706-509-6901 or email medstaff@floyd.org.

I acknowledge that I have voluntarily provided the above information, and I have carefully read and understand this Authorization. I understand and agree that a facsimile or photocopy of this Authorization shall be as effective as the original.

_____ _____

Provider Signature Print Name

_____ _____

Full NPI Number Date