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