

Atrium Health – Carolinas Gastro Centers

New Provider Information Form (PIF)

Date of Submission: Click or tap to enter a date.  **Physician**  **Allied Health Provider**

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| Provider Information | | | | | | |
| **Full Legal Name:** **Title:**  **M  F** | | | SSN: | | DOB: | NPI: |
| Current Home Address: | | | | City, State, Zip: | | |
| Phone: | Alternate Phone: | | | Preferred Email:  Alternate Email**:** | | |
| **Practicing** Specialty: | | | | | | |
| Practice Information | | | | | | |
| Primary Practice: | | | | | | |
| Practice Address: | | | | City, State, Zip: | | |
| Practice Phone: SecureFax: | | | | Clinical Start Date: | | |
| Practice Manager/Contact: | | | | | | |
| Privilege Information | | | | | | |
| **Primary Privileges location (if more than one location checked):**  **Start Date:       Canopy Date:**  **Course Type:**  **Acute (Hospital)**  **Anesthesia** | | | | | | |
| Privilege Locations**:  John J Delaney Ste/ 120**  **1001 Blythe Blvd, Ste 400** | | | | | | |
| Training Status (PHYSICIAN ONLY) | | | | | | |
| From Residency/Fellowship | | **Incoming Fellow** | |  | | |
| Additional Comments | | | | | | |
| **Notes/Comments:**  **NC State Medical License:**  **North Carolina License:**  **NC Approval to Practice:**  **Sponsoring Physician (for ACPs only):** | | | | **License – SC:**  **DEA – NC:**  **DEA – SC:**  **Taxonomy:** | | |

Please complete electronically and forward the completed PIF along with the provider’s current CV **to** [MSSproviderREQ@atriumhealth.org](mailto:MSSproviderREQ@atriumhealth.org)