Southern Regional Medical Center

# Provider Pre-Application Form

**Contact Information:**

Name: _____

Date: _____

Cell Number: _____

Email Address: _____

**Group/Primary Address:**

Practice Name: _____

Practice Address: _____

_____

_____

Phone Number: _____

Fax: _____

**Expirable:**

- Are you Board Certified?
  - ☐ Yes
  - ☐ No
  - ☐ Eligible
    Board: _____
- Do you have a Georgia License?
  - ☐ Yes
  - ☐ No
    Expiration Date: _____
- Do you have a DEA with a GA Address?
  - ☐ Yes
  - ☐ No
    Expiration Date: _____
- Insurance Provider: _____
  Expiration Date: _____
- Do you have updated ACLS, BLS, PALS, NRP?
  - ☐ Yes: _____
  - ☐ No

**Specialty Questions:**

Please Select Title:

- ☐ MD
- ☐ DO
- ☐ DPM
- ☐ NP
- ☐ PA
- ☐ CSFA
- ☐ CSA

Specialty: _____

Requested Status: _____

**Why Southern Regional?**

_____

_____

_____

_____

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_____

**Signature:** _____

**Please fax completed document, along with a CV/Resume to 770-991-8171**
**OR scan document and CV/Resume to SRGAMedicalStaff@primehealthcare.com.**