Southern Regional Medical Center

Initial Application Request Form

☐ Employed Provider
☑ Independent Contractor
☐ Group Contractor
☐ Locum Tenens

Please type/print using large block letters for legibility. A response is REQUIRED in all fields.

Date Request Sent to SRGA (mm/dd/yyyy):		
Applicant's Full Name (Must match GA Medical License):		
Applicant's Title and Specialty	Title:	
	Specialty:	
Applicant's Email and Cell Phone Number:	Cell:	
	Email:	
Applicant's NPI Number:		
Applicant's Date of Birth:		
Applicant's Social Security Number:		
Applicant's State of Georgia Medical License Number and Expiration Date:	Number:	
	Expiration:	
Applicant's DEA Number and Expiration: *(Type N/A if not applicable)*	Number:	
	Expiration:	
Applicant's Medical Practice Information:	Practice Name:	
	Address 1:	
	Address 2:	
	City:	
	State:	
	Zip:	
	Phone:	
	Fax:	
Applicant's Practice / Credentialing Coordinator Name:		
Applicant's Practice/Credentialing Coordinator Email and Phone:	Email:	
	Phone:	
Anticipated Start Date:		

This request form will not be accepted without the CV/Resume attached.