Affinity Medical Group
Provider Pre-Screening Form

☐ **Primary Care** ☐ **Specialty Care**

Provider Information

Full Name: _____ Degree: _____
SSN:_____ Gender: ____ DOB:_____License #: _____
City of Birth:_____
Practicing Specialty: _____

Have you previously applied for membership with Affinity Medical Group?
☐ Yes ☐ N If yes, please provide date: _____

Board Certifications

Primary Board Certification: _____ Expiration Date: _____

If Board eligible, when did you complete your residency or fellowship?

Date: _____ Intent Certification Date:_____

Sub-Specialty Board Certification: _____ Expiration Date: _____

If Board eligible, when did you complete your residency or fellowship?

Date: _____ Intent Certification Date:_____

☐ **Solo Practice** ☐ **Group Practice**
please provide a participating provider roster

Group: _____ Provider Name: _____

Primary Office Address: _____

Office Phone: _____ Office Fax: _____

Tax ID: _____ Languages: _____

Other IPA _____

_____

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On Call Group / MD (must be an Affinity contracted provider within your same specialty): _____

Referred by an AMG contract provider?

_____

Hospital and ASC Privileges *(Please list all Facilities with whom you hold privileges)*

Facility & City: _____ Privileges: _____

Facility & City: _____ Privileges: _____

Facility & City: _____ Privileges: _____

Facility & City: _____ Privileges: _____

Facility & City: _____ Privileges: _____

Contact Person

Name of Person Facilitating this Request: _____

Title / Position: _____ Email: _____

Phone: _____ Fax: _____

Physician Signature: _____ Date: _____