

Saint Agnes Health System – Trinity Health Center for Practitioner Information (CPI) Application Request Form

E-mail completed form to: frhsmedicalstaffsvcs@samc.com

***Red Fields are Required**

Practitioner's Name: First: _____ Middle: _____ Last: _____
Degree: <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DPM <input type="checkbox"/> DDS <input type="checkbox"/> NP <input type="checkbox"/> CRNA <input type="checkbox"/> PA <input type="checkbox"/> PhD <input type="checkbox"/> Other: _____
Date of Birth (Required - mm/dd/yyyy format): _____
Practitioner's e-mail address (Required): _____
Should MSOW record be shared with Network Mgmt? <input type="checkbox"/> Yes <input type="checkbox"/> No
Will the practitioner be part of the Employed Medical Group <input type="checkbox"/> Yes <input type="checkbox"/> No
Is the practitioner <input type="checkbox"/> Joining a group with a contracted service <input type="checkbox"/> Independent Contract <input type="checkbox"/> Other
Is practitioner still in residency? <input type="checkbox"/> Yes <input type="checkbox"/> No —————> Anticipated Grad Date: _____ <i>*Applications for June graduates will be released in March.</i>
Is the practitioner board certified? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the practitioner have a CA license <input type="checkbox"/> Yes <input type="checkbox"/> No
License #: _____ If no, has an application been submitted? <input type="checkbox"/> Yes <input type="checkbox"/> No
Anticipated start date (date of admission/case): _____ —————> Is this a "hot" file? <input type="checkbox"/> Yes <input type="checkbox"/> No
Application requested/form sent By: _____
Credentialing Contact/Delegated User (will have their own portal login/password) (Name and Email Required): _____
If you would like another individual to be notified when an application is emailed, provide name and email address: _____
Office Information: Joining an existing practice? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of practitioner to be mirrored? _____
Primary office name: _____
Office address (include city & ZIP): _____
Office phone: _____ Office fax: _____
Portal/Process: <input type="checkbox"/> AHP/APP <input type="checkbox"/> Physician
<input type="checkbox"/> Full Initial Appointment/ Credentialing (with or without clinical privileges)
<input type="checkbox"/> Abbreviated Locum Tenens Process
<input type="checkbox"/> Initial Locum to Full
<input type="checkbox"/> Add/Mid-Cycle Privileges (already on staff at hospital). If a reference is required, provide name & email below
<input type="checkbox"/> Add Facility (portal summary w/in last 6 mo & launch "Add Facility" portal). If a reference is req, provide name & email below
Reference Name (for Add Privileges/Add Facility): _____
Reference Email: _____

To which facility(ies) is the practitioner applying? *Indicate which privilege forms on page 2.*

Saint Agnes Medical Center

Saint Agnes Medical Foundation

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Saint Agnes Medical Center		
AHP/APPs	<input type="checkbox"/> Family Practice	<input type="checkbox"/> Otolaryngology
<input type="checkbox"/> APP – CRNA	<input type="checkbox"/> Gastroenterology/ Endoscopy	<input type="checkbox"/> Palliative Medicine
<input type="checkbox"/> APP – NP	<input type="checkbox"/> General Surgery	<input type="checkbox"/> Pathology
<input type="checkbox"/> APP – PA	<input type="checkbox"/> Hand Surgery	<input type="checkbox"/> Pediatrics
<input type="checkbox"/> APP – RNFA	<input type="checkbox"/> Hematology/ Oncology	<input type="checkbox"/> PM & R
<input type="checkbox"/> APP – RNFA Intern	<input type="checkbox"/> Hyperbaric & Wound Care	<input type="checkbox"/> Plastic Surgery
PHYSICIANS	<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Podiatry
<input type="checkbox"/> Allergy & Immunology	<input type="checkbox"/> Internal Medicine	<input type="checkbox"/> Psychiatry
<input type="checkbox"/> Anesthesiology	<input type="checkbox"/> Neonatal/ Perinatal Medicine	<input type="checkbox"/> Pulmonary Medicine
<input type="checkbox"/> Cardiology	<input type="checkbox"/> Nephrology	<input type="checkbox"/> Radiation Oncology
<input type="checkbox"/> Cardiothoracic Surgery	<input type="checkbox"/> Neurological Surgery	<input type="checkbox"/> Radiology
<input type="checkbox"/> Colon & Rectal Surgery	<input type="checkbox"/> Neurology	<input type="checkbox"/> Rheumatology
<input type="checkbox"/> Critical Care	<input type="checkbox"/> OB/GYN	<input type="checkbox"/> Thoracic Surgery
<input type="checkbox"/> Dentistry	<input type="checkbox"/> Occupational Medicine	<input type="checkbox"/> Urology
<input type="checkbox"/> Dermatology	<input type="checkbox"/> Ophthalmology	<input type="checkbox"/> Vascular Surgery
<input type="checkbox"/> Emergency Medicine	<input type="checkbox"/> Oral & Maxillofacial Surgery	
<input type="checkbox"/> Endocrinology	<input type="checkbox"/> Orthopedic Surgery	