ORLANDO HEALTH®

_____ DELEGATED PROVIDER (Check if delegated and complete Provider Name and Credentials, Credentialing, Recruiter and Practice Manager Information)

Data Sheet for New Provider On-Boarding

All information must be correct and complete. Incomplete forms will be returned and No Credentialing Action will be taken until form is completed and a CV is attached. Indicate N/A if an area is not applicable. Scan and email to:

R-initialapp@orlandohealth.com

Provider Name as it appears on state license. Florida license verification is available at: https://appsmqa.doh.state.fl.us/MQASearchServices/Home If middle name or initial appear on license, please include in first name block.	First:	Last:
Provider Credentials (MD, DO, CRNA, APRN, PA-C, etc.)		
Is the provider Board Certified? (Yes/No) Physicians must be board certified or meet eligibility requirements outlined on Orlando Health Bylaws. https://www.orlandohealth.com/medical-professionals/medical-staff-services Allied Health Professionals must be board certified except for CRNA has one year from completion of training program to achieve certification.	Name of Certification Board(s): 1. 2. Date Issued: 1. / / 2. / / Expiration Date: 1. / / 2. / / Date exam taken: or scheduled if eligible:	
If APP, list primary supervising physician name		
Provider Social Security Number		
Provider Birthdate		
Provider Gender		
Provider Cell Phone Number		
Provider E-mail		
Does provider have a Florida license? (Yes/No) If yes, what is the license number? If no, what date did provider apply for FL license?	License #: Date:	
DEA Number	#	
Provider NPI Number – Obtain from provider or NPPES website: https://npiregistry.cms.hhs.gov/ If no NPI, Provider will need to apply for it. Please mark "None" in that case.		
CAQH	#	
Medicare ID	#	
Medicare ID	#	
Start Date		
Primary Practice Name		
Primary Practice Street Address		

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Primary Practice City, State, Zip		
Tax ID #		
Is this a new practice at this address? (Circle one)	Yes	No
Will this new provider be accepting new patients?	Yes	No
Will this provider be performing inpatient or outpatient services? (Circle all that apply)	Inpatient	Outpatient
Will this provider require admitting privileges?	Yes	No
Will this provider be working full time? (If No, specify number of hours per week.)	Yes	No – Part time / Number of hours per week _____
Please list ***all other*** practice locations where this provider will see patients or cover PRN. Indicate set hours at these locations. **Practice Name:**	**Location:**	
1.		Hours:
2.		Hours:
3.		Hours:
4.		Hours:
What is the provider's specialty? List all applicable specialties.		

Provider Primary Hospital (please check one ONLY):	☐ Orlando Regional Medical Center (ORMC) ☐ Arnold Palmer/Winnie Palmer Hospital (APMC) ☐ Dr. P. Phillips Hospital (DPPH) ☐ South Seminole Hospital (SSH)
Will this provider need privileges at HC and/or SOLK/SLK?	☐ Health Central Hospital (HC) ☐ Southlake Hospital (SOLK/SLK) ☐ Not Applicable (N/A)

Complete information below if individual needs to be notified for credentialing updates.

Credentialing Contact Name: Phone number: E-mail Address:	Practice Manager/Administrator Name: Phone number: E-mail Address:
Recruiter Name: Phone number: E-mail Address:	Other Name: Phone number: E-mail Address: