ORLANDO HEALTH®

Provider CVO Interest Form

Please complete form and return with a copy of the applicant CV to OrlandoHealthCVO@orlandohealth.com

APPLICANT INFORMATION

PCP ❑ **SPECIALIST** ❑ **APRN/PA-C** ❑ **BEHAVIORAL** ❑ **OTHER:** _____

CVO Request Type: **New Applicant Credentialing** ❑
New Facility Affiliation ❑
Requesting privileges at an additional Facility

Anticipated Start Date: _____	**Currently in an Orlando Health Residency/Fellowship?** ❑ **Yes** ❑ **No**	**Graduation Date:**
Provider First Name:	Middle Name:	Last Name:
Degree: (MD, DO, PA-C, APRN)	Gender:	Aliases:	CAQH Number:
NPI:	FL Med License # or Status	Provider Cell Number:
Provider's Personal Email:		

PRIMARY PRACTICING SPECIALTY: (If requesting hospital privileges, list the specialties you are requesting privileges for)

Practicing Specialty:	Board Certified: Yes ❑ No ❑ Eligible ❑ Board Name:	Date Exam Taken/Scheduled:

SECONDARY SPECIALTY (If applicable)

Secondary Specialty:	Board Certified: Yes ❑ No ❑ Eligible ❑ Board Name:	Date Exam Taken/Scheduled:

PRIMARY PRACTICE INFORMATION

Name of Practice/Group:

Address:	City:	Zip:
Suite Number:	Office Phone Number:	Office Fax:
Practice Manager Name:	Phone Number:	Email:
Credentialing Contact Name:	Phone Number:	Email:

APRN/PA-C (APPs) must list supervising physician:

Request for Privileges and/or Membership (Please identify all facilities you will be practicing from using the below options)

Have you ever been previously Employed, Granted Privileges or a Hospital Membership with Orlando Health? Yes ❑ **No** ❑

Which of all the selected hospitals below will be your Primary Location? _____

O.D.S.A.W ❑ **Primary Hospital** ❑
ORMC, Dr. Phillips, South Seminole, Arnold Palmer and Winnie Palmer Hospitals
List main O.D.S.A.W Location: _____

Select the Staff Category that best describes your intended activity?

- ❑ **Active:** Min. of 12 patient contacts per yr.
- ❑ **Courtesy:** Max. of 12 patient contacts per yr.
- ❑ **Active Affiliate:** Membership only
- ❑ **Locum Tenens:** Active privileges for 120 days. Non-membership status.
- ❑ **Telemedicine:** Contracted physicians only

Application Fees:
Physician Fee: $500
Allied Health Fee: $250

Health Central & Horizon West Hospitals ❑ **Primary Hospital** ❑

Select the Staff Category that best describes your intended activity?

- ❑ **Active:** Min. of 12 patient contacts per yr.
- ❑ **Courtesy:** Max. of 12 patient contacts per yr.
- ❑ **Active Affiliate:** Membership only
- ❑ **Telemedicine:** Contracted physicians only

Application Fees:
Physician Fee: $400
Allied Health Fee: $250

South Lake Hospital ❑ **Primary Hospital** ❑

Select the Staff Category that best describes your intended activity?

- ❑ **Active:** Min. of 12 patient contacts per yr.
- ❑ **Courtesy:** Max. of 12 patient contacts per yr.
- ❑ **Active Affiliate:** Membership only
- ❑ **Locum Tenens:** Active privileges for 120 days. Non-membership status.
- ❑ **Telemedicine:** Contracted physicians only

Application Fees:
Physician Fee: $500
Allied Health Fee: $300

Please indicate whether your provider has current privileges at one of the facilities below?

Bayfront Hospital ❑	**St. Cloud Hospital** ❑