Presbyterian HEALTHCARE

PERSONAL PRACTICE AND/OR ADDRESS CHANGE FORM

Name: (print full name)_____

Please choose all options below that apply:

❑ I am **relocating or changing** my personal office practice within the Charlotte area and wish to maintain my privileges.
Effective Date_____ This is a _____new practice location replacing my old address **OR** ____an additional practice location.

· Staff level requested at Presbyterian Hospital/POH: ❑Active ❑Courtesy ❑Consulting ❑Affiliate

· Staff level requested at Presbyterian Hospital Matthews: ❑Active ❑Courtesy ❑Consulting ❑Affiliate

· Staff level requested at Presbyterian Hospital Huntersville: ❑Active ❑Courtesy ❑Consulting ❑Affiliate

· New Group Name_____ **OR** ❑ No Change

Address_____
Street Address *City* *Zip Code*

Phone/Fax_____
Office *Fax* *Private Line* *Beeper*

Office Manager Phone_____Office Manager Email:_____

· Patients assigned to me in the hospital computer should: ____remain with me or _____be reassigned to _____

· If you are a solo practitioner, you must provide us with the name of a back-up physician:_____
(Note: You must also submit a letter of agreement from the back-up physician) _____Not applicable

· _____I am enclosing a copy of my new malpractice coverage (required for changes in practice/group affiliation)

❑ **Update my Cell phone**_____ - this number _____may or _____may not be released to nursing or others

❑ **Update my Beeper**_____ - this number _____may or _____may not be released to nursing or others

❑ **Update my Email** address_____
Email_____may or _____may not be released to others

❑ **Update my home address/phone information:** Home Telephone_____❑ private – do not release

_____
Home Street Address *City* *Zip Code*

❑ I am **resigning** my medical staff appointment/privileges due to relocating outside the Charlotte area. effective_____
· My patients should be referred to Doctor _____, who has agreed to accept them.
· My forwarding address is_____

❑ I have **retired** or planning to retire effective _____ and I am therefore requesting deactivation of my hospital privileges. Check here_____if you would like to request a status change to "honorary" staff. I would like to continue to receive hospital mailings at the following address_____

❑ I am planning to **resign/retire** from my group effective _____, but would like to request a "**Leave of Absence**" to temporarily deactivate privileges until I make a decision about possible practice plans. I understand that such leave cannot extend beyond one year and that I must furnish the Medical Staff Office with new practice information and malpractice coverage before requesting reactivation of my privileges. I understand that I must complete the "Request for Reinstatement from Leave of Absence" form and have my request submitted to the Credentials Committee for action prior to my return. I will allow at least four (4) weeks for processing my request to return to staff. I also understand that I may be requested to provide additional information as deemed necessary by the Credentials Committee. I would like to continue to receive hospital mailings at the following address: _____

SIGNATURE: _____ **DATE:** _____

Fax form to (704) 316-9463 or mail to Lisa Bowers at the following address:
Medical Staff Services • 200 Hawthorne Lane • Post Office Box 33549 • Charlotte, NC 28233-3549