

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 Thomasville 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 Thomasville Medical Center: Active Associate 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 Thomasville 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 336-474-3484 attn: Janice Berrier