CENTRA

EXTERNAL PROVIDER NEW HIRE FORM

Provider Information

Providers Legal Name:_____Degree:_____
Last First Middle Suffix

Mailing Address: _____
Street Address Apartment/Unit #

_____
City State ZIP Code

Home Phone:_____ Mobile Phone: _____

Preferred Email Address:_____Date of Birth: _____

Provider's NPI Number: _____ VA BOM #_____ VA DEA #_____
Are you in a residency or fellowship program?_____If so, expected completion date: _____

Agency Company, if applicable:_____Agency Contact: _____

Agency Contact Phone:_____Agency Contact Email: _____

Practice Information

Centra Facility(s) Requested: ☐ BMH ☐ LGH/VBH/Gretna ☐ Southside ☐ Centra Specialty
☐ Provider will be on-site or ☐ Tele Privileges Only

Specialty:_____***Anticipated Date (110 days)**:_____

Supervising Physician, for APPs: _____

Alternative Supervising Physician, for APPs: _____

Practice Name: _____

Practice Address: _____
Street Address Suite #

_____
City State ZIP Code

Practice Phone:_____ Practice Fax: _____

Practice Email Address:_____Practice Contact: _____

Professional Malpractice Carrier with Liability limits: _____

Request Submitted By:_____Request Date: _____

***Anticipated start date to reflect 110 Business days; 90 Business days from receipt of completed application.**

****Attach current CV in month/year to month/year format to External New Hire Request Form**