St. Clair Health
St. Clair Hospital

INITIAL APPOINTMENT REQUEST FORM

ALL REQUESTS MUST BE COMPLETE AND LEGIBLE TO BE PROCESSED.

I. Personal Information

First Name ____ Middle Name ____ Last Name ____ Professional Suffix ____

Practitioner Email Address ____ Date of Birth ____

NPI (if you do not yet have an NPI, SSN) ____ Cell Phone ____

Home Address – Street ____ City ____ State ____ Zip ____

II. Primary Clinical Practice Information For Appointment At St Clair Hospital

Practice/Group Name ____ Phone ____ Fax ____

Primary Address – Street ____ City ____ State ____ Zip ____

Contact Person Name ____ Contact Person Email ____ Contact Person Phone ____

Covering/Supervising/Collaborating Physician Name ____ Requested Start Date* ____ Staff Category ____

*See processing calendar for available start dates. Note: ASAP is NOT acceptable.

III. Primary Clinical Practice Certification Information

Are you certified? ☐Yes ☐No If yes, certification(s) ____

If no, are you eligible? ☐Yes ☐No Anticipated Exam Date:____

Provide a short explanation as to why you want to be associated with St. Clair Hospital:

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By submitting this application request, I attest to the best of my knowledge, the applicant meets the Threshold Eligibility Criteria as outlined in the Medical Staff Credentials Policy.

Name of person submitting request ____ Date ____

Please submit a completed copy of this form along with the following documentation to StClairMSO@StClair.org.

- Current CV
- Recent NPDB self-query (within 30 days) https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp
- PA-C/CRNP only – copy of current/submitted written/collaborative agreement.