

NOT APPLICABLE

**Re-credentialing Application part 4
PROVIDER LOCATION INFORMATION**

(Please complete if the information has changed during the previous 36 months)

******Please complete for one form for each location******

Location Address _____

Office Phone _____ Office Fax _____

Office Contact Name _____ Title _____

Check One: Solo Practice _____ Group Practice/ Number of Doctors _____

Please List Names of All Doctors Practicing at this Location: _____

Office Size (in sq. feet): _____ # of Treatment Tables: _____

Number of Examination Rooms: _____

Georgia X-Ray Certification (Yes/No): _____ Last Date Certified: _____

Type of Facility: Free Standing _____ Medical Bldg. _____ Office Bldg. _____

Storefront _____ Other _____

Does Your Office Provide For Handicap Access? _____

Emergency(Urgent Care) Service? (Yes or No) _____ If Yes, By Whom? _____

24 Hour Method of Access: Answering Service: _____ Pager: _____

Home Number _____ Other: _____

Do You Provide Physiotherapy On-Site? _____

If No, do you have a Referral Affiliation with a Physiotherapy or Rehabilitation Facility? _____

Do You Have Ownership In These Facilities? _____

PRACTICE INFORMATION:

Patients are seen within _____ hrs./days for Urgent Care & _____ hrs./days for Non-Urgent Care.

Do you take History, Physical, and X-Rays at the Initial Visit for all Patients? _____

Do you Routinely Prepare a Written Plan of Treatment During your Initial History & Physical? _____

Do you have Ownership in any Facility/Place/Practice to which you Refer Patients? _____

If Yes, Please Describe: _____

Since Practicing, Has There Ever Been Greater Than A Thirty Day Period In Which You Did Not Practice? _____ If Yes, Please Explain: _____