

Conway Regional Physicians Hospital Organization Membership Application

Please complete this form if you wish to apply to be affiliated with the Conway Regional Physician Hospital Organization (PHO). The completed application may be mailed (PO Box 10525, Conway, AR 72034), faxed (501-327-6183), emailed (phoadmin@conwaycorp.net), or hand delivered (930 Wingate, Suite C1) to the PHO office. Any questions regarding completing the application should be emailed to the above address.

Once the application is received by the PHO, it generally will take a month or more to process. The PHO Board has the right to ask questions, which may cause the process to take somewhat longer. We suggest the application be submitted as early in the onboarding process as possible to allow time for processing.

All questions must be answered for the application to be processed by the PHO.

PROVIDER NAME/TYPE Name: _____ MD _____ DO _____ Nurse Practitioner _____ Physician Assistant _____ Podiatrist _____ Optometrist _____ Dentist _____ Mental Health (specify type) _____

LICENSE By What Agency _____ Since What Date _____
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FACILITY STAFF (Currently on or applying for) CRMC _____ All Other (list) _____ CRMC Active _____ Consulting _____ Courtesy _____ Allied _____ N/A _____ Other 1) Active _____ Consulting _____ Courtesy _____ Allied _____ N/A _____ Other 2) Active _____ Consulting _____ Courtesy _____ Allied _____ N/A _____

PRACTICE LOCATION Full Address (Practice Name, Street, C/S/Z) _____ Cl. Phone _____ Fax _____ Email Address _____ Average Hours/Week Worked: Full Time _____ Other _____
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EMPLOYMENT Date Begun or to Begin Employment _____ Provider is Employed By: Self _____ Other (name) _____
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MISCELLANEOUS

How became aware of the PHO? _____

Primary reason for applying? _____

Providers in the area you refer to/from (if you have been in practice) _____

Anything else for Board's consideration _____
