ARKANSAS AMBULATORY SURGERY ASSOCIATION

2010 MEMBERSHIP APPLICATION

Facility: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (If different from above):

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____) _____ - _____ Fax: (_____) _____ - _____

Please list the contact person to whom AASA information should be sent:

Name: _____ Title: _____

Key Personnel

NAME E-MAIL ADDRESS

Administrator: _____

Nurse Manager: _____

BOM: _____

Other: _____

General Center Information

Please check the appropriate areas:

Licensed by the Arkansas Department of Health ❑

Certified by CMS ❑

Accredited by: AAAHC ❑ JCAHO ❑ Other: ❑

Ownership: Corporation ❑ Hospital JV ❑ 100% MD Owned ❑

Type: Freestanding In-hospital Office Based Surgery Center ❑

Date ASC opened: _____

Number of Operating Rooms: _____ Number of Procedure Rooms: _____

Current employees: Full Time_____ Part Time_____ PRN_____

Number of Surgeons on current Medical Staff:_____

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Average Number of cases/month: _____

Types of Procedures Performed:

	YES	NO		YES	NO
ENT	_____	_____	Oral/Dental	_____	_____
General	_____	_____	Orthopedic	_____	_____
GI	_____	_____	Pain Mgmnt.	_____	_____
GYN	_____	_____	Plastic	_____	_____
Lithotripsy	_____	_____	Podiatry	_____	_____
Neurology	_____	_____	Steriotactic	_____	_____
Ophthalmology	_____	_____	Urology	_____	_____

Other types of procedures not listed above:

_____

_____

_____

Committee Information:
Please choose a committee you would like to participate on
(all applicants must sign up for a committee):

Education Committee ❑ Membership Committee ❑ Benchmarking Committee ❑

I/We hereby apply for membership in the Arkansas Ambulatory Surgery Association (AASA) for 2010 and I/we agree to abide by the bylaws and Rules and Regulations of the Association as may be, from time-to-time, enacted by the Association. I/We state that the information contained within this Application for Membership is true and correct to the best of my/our knowledge.

_____ _____

(Signature) *(Date)*

Your prorated 2010 membership fee is: $300.00 if paid prior to April 30, 2010

Please make your check payable to AASA and mail your check with this application for membership to:

Arkansas Ambulatory Surgery Association
c/o Galise Svoboda
1521 Pinecroft
Benton, AR 72019