

**PENNSYLVANIA AMBULATORY SURGERY ASSOCIATION
FACILITY MEMBERSHIP APPLICATION
YEAR 2012**

FACILITY NAME: _____

ADDRESS: _____

CITY, STATE, ZIP _____

TELEPHONE NUMBER: _____ **FAX NUMBER:** _____

MEMBER STATUS: () NEW () RENEW

PLEASE LIST CONTACT PERSON TO WHOM PASA INFORMATION SHOULD BE SENT:

NAME: _____ **TITLE:** _____

E-MAIL ADDRESS: _____

PLEASE PROVIDE THE FOLLOWING INFORMATION REGARDING YOUR SURGERY CENTER:

ACCREDITED: ___AAAHC ___MEDICARE ___JACHO _____OTHER (SPECIFY)

(CHECK ALL THAT APPLY)

OWNERSHIP: ___ CORPORATION ___ PARTNERSHIP _____ OTHER (SPECIFY)

TYPE: ___ HOSPITAL AFFILIATE ___ NON-HOSPITAL AFFILIATION

DATE OPENED: _____ **NO. Ors:** ___ (1) ___ (2) ___ (3+)

CURRENT STAFF: _____ FULL-TIME _____ PART-TIME

NUMBER OF CASES PERFORMED IN PAST FISCAL YEAR: _____

NUMBER OF CURRENT MEDICAL STAFF MEMBERS: _____

SINGLE SPECIALTY: ___ **SPECIALTY:** _____ **MULTI-SPECIALTY:** _____

ALTERNATE REPRESENTATIVE (NAME _____

EMAIL _____

I understand that contact information may be shared with others. Check here to be excluded from a contact list. ___

MEMBERSHIP TYPE: ___ Facility Member - \$500.00
 ___ Associate Member (Business vendors, Non-Facility Members) - \$500.00

PASA has a contractual arrangement with a lobbyist and a portion of your membership dues will be used for lobbying activities. At the end of our fiscal year, you will receive a statement detailing the percentage of membership dues that were used for lobbying activities.

PLEASE FORWARD APPLICATION AND A CHECK (PAYABLE TO PASA) TO:
PASA Administrative Secretary
Pennsylvania Medical Society
777 East Park Drive, PO Box 8820
Harrisburg, PA 17105-8820
