



OASCA Membership Application Form

Legal Name of Facility _____

Facility Address _____

City/State/Zip _____

Telephone _____ Fax _____

Is your facility a member of the Oregon Patient Safety Commission? Yes No

LEGAL TYPE

<input type="checkbox"/> LLC	<input type="checkbox"/> Physician Partnership	<input type="checkbox"/> % Owned by Physician
<input type="checkbox"/> Corporation	<input type="checkbox"/> Management Contract	<input type="checkbox"/> % Owned by Hospital
<input type="checkbox"/> Sole Proprietor	<input type="checkbox"/> Other	<input type="checkbox"/> % Owned by Other

ACCREDITATION

Please enclose a copy of ONE of the following Certificates with your payment.

<input type="checkbox"/> AAAHC Accreditation	<input type="checkbox"/> Medicare # _____
<input type="checkbox"/> JCAHO	<input type="checkbox"/> OTHER _____

FACILITY TYPE

<input type="checkbox"/> Free-Standing	<input type="checkbox"/> Single Physician with one operating room
<input type="checkbox"/> Multi-Specialty	<input type="checkbox"/> Hospital Affiliated
<input type="checkbox"/> Single-Specialty	<input type="checkbox"/> If single specialty, please identify _____

Number of Operating Suites _____	Number of Annual Surgeries _____
Number of Procedure Rooms _____	Number of Annual Procedures _____
Year Facility Opened _____	

PERSONNEL

Administrator: _____ Email: _____

Business Manager: _____ Email: _____

Medical Director: _____ Email: _____

Clinical Director: _____ Email: _____

MEMBERSHIP FEE SCHEDULE

**Membership Fees are due upon joining and are billed annually.

- \$ 1,500.00 for ASC performing 2501 or more cases (patient encounters) per year.
- \$ 1,000.00 for ASC performing 1001 or more cases (patient encounters) per year.
- \$ 750.00 for ASC performing 500 or more cases (patient encounters) per year.
- \$ 750.00 for Medical Groups.
- \$ 500.00 for ASC not yet operational.
- \$ 500.00 for Single Physicians.
- \$ _____ **Donation of Additional Funds for Lobbying**

PLEASE MAKE YOUR CHECK PAYABLE TO: **OASCA**
 SEND CHECK, APPLICATION, and ACCREDITATION CERTIFICATE TO:

**PO Box 19387
 Portland Oregon 97280**

Administrative Use Only

Check # _____

Amount \$ _____

Date Rec'd _____

Batch # _____

Contact Information

Phone: 206-992-3330 Fax: 206-824-4237 E-Mail: pattim@oregonasc.com