



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

LLC Physician Partnership % Owned by Physician
 Corporation Management Contract % Owned by Hospital
 Sole Proprietor Other % Owned by Other

ACCREDITATION

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

AAAHC Accreditation Medicare #
 Joint Commission OTHER _____

FACILITY TYPE

Free-Standing Single Physician with one operating room
 Multi-Specialty Hospital Affiliated
 Single-Specialty 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: _____ E-mail: _____
 Business Manager: _____ E-mail: _____
 Medical Director: _____ E-mail: _____
 Clinical Director: _____ E-mail: _____

MEMBERSHIP FEE SCHEDULE

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

- \$ 2,000.00 for ASC performing 2501 or more cases (patient encounters) per year.
- \$ 1,500.00 for ASC performing 1001 or more cases (patient encounters) per year.
- \$ 1,000.00 for ASC performing 500 or more cases (patient encounters) per year.
- \$ 800.00 for Medical Groups.
- \$ 500.00 for ASC not yet operational.
- \$ 600.00 for Single Physicians.

Administrative Use Only

Check # _____

Auth. # _____

Amount \$ _____

Date Rec'd _____

Batch # _____

PLEASE MAKE CHECK PAYABLE TO: OASCA
 SEND CHECK, APPLICATION, and ACCREDITATION CERTIFICATE TO:
OASCA 17837 1st Avenue South PMB #297 Normandy Park WA 98148

Credit Card Type

Visa MasterCard Credit Card Number: _____
 Expiration Date: ____/____/____ CVV #: _____ CardholderName _____
 Billing Address: _____ City _____ State _____ Zip _____
 Signature _____