PENNSYLVANIA AMBULATORY SURGERY ASSOCIATION
MEMBERSHIP APPLICATION
YEAR 2017

MEMBERSHIP TYPE: ☐ **Facility Member** - $500.00
☐ **Associate Member – Individual** - $500.00
☐ **Associate Member – Organization/Vendor** - $500.00

MEMBERSHIP STATUS: ☐ NEW ☐ RENEW

FACILITY/COMPANY/INDIVIDUAL NAME: ______________________________

ADDRESS: ______________________________

CITY, STATE, ZIP ______________________________

TELEPHONE NUMBER: ______________________ FAX NUMBER: ______________________

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

NAME: ______________________ TITLE: ______________________

E-MAIL ADDRESS: ______________________________

ALTERNATE REPRESENTATIVE (NAME): ______________________________

EMAIL ADDRESS: ______________________________

PLEASE PROVIDE ALL OF THE FOLLOWING INFORMATION REGARDING YOUR SURGERY CENTER:

DATE OPENED: ______________

ACCREDITATION: ☐ AAAHC ☐ TJC ______________ OTHER (SPECIFY) MEDICARE CERTIFIED: ☐ YES ☐ NO

OWNERSHIP INTEREST: LIST PERCENTAGE %

________ HOSPITAL ________ PHYSICIAN ________ MANAGEMENT COMPANY ________ OTHER

RATES RECEIVED: ☐ MEDICARE ASC RATES OR ☐ *HOSPITAL OUTPATIENT

*Please contact the PASA Administrative Office about membership eligibility

OF CASES PERFORMED IN PAST FISCAL YEAR: ________

OF CURRENT MEDICAL STAFF MEMBERS: ________ NUMBER OF ORs: ________

SINGLE SPECIALTY: ________ SPECIALTY: ______________________ MULTI-SPECIALTY: ________

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

NOTE: 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 see dues amounts listed at the top of the page.

☐ My check/money order is enclosed (Payable to PASA in US Dollars, drawn on a US bank/institution), **OR**

☐ I would like to pay my dues by Visa, MasterCard, or Discover as follows (complete all information):

Visa/MasterCard/Discover #________-________-________-________-________ Exp. Date______/______ 3 Digit Security Code ______________

Name printed on Card ______________________________

Card Address ______________________________

Total amount to be charged $________________

Authorized Signature ______________________________

PLEASE FORWARD APPLICATION AND PAYMENT TO:

PASA MSS, PAMED, 777 East Park Drive, PO Box 8820, Harrisburg, PA 17105-8820, Harrisburg, PA 17105-8820