American Association for Accreditation of Ambulatory Surgery Facilities

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Gurnee, Illinois 60031

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FACILITY IDENTIFICATION

Facility I.D. Number _____ (to be assigned by AAAASFI)

Facility/Medical Director _____

Name of Facility _____

Address _____ Suite # _____

City _____ Country _____ Postal Code ___ - _____

Phone _____ Fax _____

Website_____ Email_____

Name(s) of Clinic Owner(s). Controlling Stockholder and/or Beneficial Ownership

_____ _____

_____ _____

(List Additional Names on Separate Sheet)

OR Manager/Head Nurse: _____

Current AAAASFI Class of Facility: _____

ACCREDITATION HISTORY

( ) Not Previously Accredited by AAAASFI ( ) Previously Accredited by AAAASFI

Initial Inspection Date _____ Class _____

Last Reinspection Date _____ Class _____

Other Accreditation _____ Date: _____

_____ Date: _____

Facility Licensure _____ Date: _____

_____ Date: _____

Facility/Medical Director Signature _____ Date_____