CONNECTICUT ASSOCIATION *of* AMBULATORY SURGERY CENTERS

Membership Application

A. Facility/In Development Applicant

_____
Ambulatory Surgery Center Name Corporate Owner (if applicable)

_____
Address

_____ _____ _____
City State Zip

_____ _____
Medical Director Facility Manager/Name/Title

_____ _____
Telephone Fax

_____ _____
Email Timeframe for Completion

B. License/Accreditation Information

1. State License Number_____
2. Medicare Certification Number_____
3. Accreditation Yes_____ No_____

   Type_____

C. Dues Enclosed **(See Invoice)**

Remit to: Connecticut Association of Ambulatory Surgery Centers
22 Avalon Drive
Avon, CT 06001