

**AAAASF International Accreditation Application**

AAAASF will not process incomplete applications or applications without payment. They will be returned to the facility for completion.

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| Date: |
| Accreditation program (check one):\_\_ Surgical \_\_ Dental | Facility Class (check one):\_\_ A \_\_ B \_\_ C-M \_\_ C |
| **Specialty Information (to be determined by the Facility/Medical Director)**Please list primary specialty, if more than one, add secondary specialty. **List all specialties as stated on board certification(s).**Primary specialty: Secondary specialty: Legal business name of facility (not DBA name): Facility/Medical Director name: Facility/Medical Director email address: Office manager/head nurse name: Previously accredited or denied accreditation by any accrediting organization?\_\_ No \_\_ Previously Accredited \_\_ Denied Name of Accrediting Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Please Note:* Previous denial by AAAASF or another accreditation agency does not preclude application for accreditation. Any facility may reapply for accreditation at any time following receipt of a denial notification.
* Failure to disclose previous accreditation, denial or revocation thereof may result in denial or loss of AAAASF accreditation.
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| Alternate Facility Name (if applicable): | Type of Alternate Facility Name: \_\_ Doing Business As (DBA) Name\_\_ Other (Specify): |

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| **Facility Location Information:** |
| Address Line 1: |
| Address Line 2: |
| Province/State: | Country | Zip: |
| Telephone Number: | Fax Number: |
| Website Address: | Email Address: |
| **Facility Contact:** (We will contact this person if questions arise during the processing of this application.) |
| Contact Name: | Email Address: |
| Telephone Number: | Fax Number: |

**Physician/Surgeon Name: Medical Specialty:** (as stated by board certification) **License Number:**

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| **1.** |  |  |
| Email address: |
| **2.** |  |  |
| Email address: |
| **3.** |  |  |
| Email address: |
| **4.** |  |  |
| Email address: |
| **5.** |  |  |
| Email address: |
| **6.** |  |  |
| Email address: |
| **7.** |  |  |
| Email address: |
| **8.** |  |  |
| Email address: |
| **9.** |  |  |
| Email address: |
| **10.** |  |  |
| Email address: |

# The following documentation must be sent along with the completed application by email or fax to:

**AAAASF**

**7500 Grand Ave, Suite 200**

**Gurnee, IL 60031**

**reception@aaaasf.org**

**Fax: 847-775-1985**

* + A Floor plan of the facility (label: Procedure, Recovery, Clean/Dirty and Prep/Scrub area
	+ Copy of each physician’s medical license
	+ Certificate of Training or a document equivalent to Board Certification for all physicians listed on the application
	+ Hospital Privileges for each physician on staff or an Agreement between the Hospital and Surgery Center

# The following forms also need to be completed:

* + Completed Anesthesia Validation Form
	+ Facility Identification Form signed by Medical Director.
	+ Staff Identification Form
	+ Facility Director’s Attestation signed by Medical Director.

**Payment Information**

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| **ANNUAL FEES FOR INTERNATIONAL ACCREDITATION ALL PROGRAMS** |
| **Number of Dentist / Physicians / Diagnostic Personnel** | **Annual Fee (does not include Survey fee)** |
| Small, 1 to 3 | $1,545 |
| Medium, 4 to 9 | $4,100 |
| Large, 10 to 20 | $7,100 |
| Over 20 | Negotiated Fees |
| Annual fee based on the total number of dentists, physicians or diagnostic personnel and total number of specialties of the dentists, physicians or diagnostic personnel. |
| Facilities may not request an expedited survey. |
| Annual fee and survey fees are subject to change. |

# Annual Fees for International Programs once accredited

**The on-site survey fee is $1,900 due at application and every three years thereafter.**

Check payments are not accepted for international facilities.

Only wire transfer and credit card payments are accepted for Visa / MasterCard / American Express

Name on card: Card #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CVV Code #:\_\_\_\_\_\_\_\_\_ Expiration Date: /

Payment Amount: $

Signature:

*Please direct questions regarding payments and/or wire transfers to accounting@aaaasf.org.*

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| If your bank uses ABA numbers for wire transfers, follow the**ABA Transfer Information:**NorthSide Community Bank ABA 0719256805103 Washington StreetGurnee, IL 60031Beneficiary:AAAASF International 7500 Grand Ave, Suite 200Gurnee, IL 60031Account Number: 107739Amount Transferred: $ (please include additional $25 for bank fees): | If your bank uses SWIFT codes for wire transfers, follow the**Swift Transfer Information:**TIB-The Independent BankersBank 2151 W White Oaks Drive Springfield, IL 62704SWIFT code: TIBBUS44Beneficiary:071925680 – NorthSide Community Bank 5103 Washington StreetGurnee, IL 60031For Further Credit:AAAASF International 7500 Grand Ave, Suite 200Gurnee, IL 60031Account Number: 107739Amount Transferred: $ (please include additional $25 for bank fees): |

**Payment and Billing**

AAAASF will not process applications without payment. Provide your billing contact below for any questions regarding your facility’s payment.

Billing Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Contact Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Billing Contact Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Payment by credit card

You may submit your application via email to accounting@aaaasf.org or if you prefer, you may pay with a credit card over the phone. A member of our accounting department will contact you at the number above. If the billing contact is not reached by the end of the day, this application will be destroyed and will have to be resubmitted. Applications will not be held for more than 24 hours.

If the credit card is declined, a member of the accounting department will call the billing contact for an alternate credit card. If billing contact cannot be reached by the end of the day, this application will be destroyed, and it will have to be resubmitted. Applications will not be held for more than 24 hours.

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| --- | --- | --- | --- | --- |
| Credit card type: | Visa | MasterCard | American Express | Discover |
| Name on card: |  | Card #: |  |
| Billing zip code: |  | Three-digit code: | Exp. Date: | Signature |

***Fee and refund policy:***

*The first-year accreditation annual fee plus the initial survey fee is due with each accreditation application. Additional fees will apply if special survey requests are made or for those facilities located outside the continental USA.*

*If the facility withdraws its application after it has been submitted and processed, AAAASF will refund 50% of the annual fee and 100% of the survey fee if the facility has not been surveyed. If the facility was surveyed, only 50% of the annual fee would be refunded. No refunds are issued after the facility is fully accredited.*

*If the facility has not confirmed a survey date within 12 months of the date of application submission, a new application and appropriate fees are required.*

*In the event that a survey date is confirmed prior to the 12-month timeframe but will occur beyond that timeframe (the confirmed survey date cannot be beyond three months after expiration) the survey cannot be postponed, rescheduled, or cancelled. If such occurs, the facility must re-apply for accreditation and re-submit the survey and annual fee. No refunds will be issued if the application expires.*

*Once an anniversary date is established upon achieving accreditation, the facility will be invoiced six months prior to the annual anniversary date. If a facility does not pay its fees by the due date on the invoice, late fees will be applied, and other penalties will follow. If the facility’s accreditation is revoked or terminated for any reason, no fees are refunded.*