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**AAAASF ACCREDITATION APPLICATION**

**Application will not be processed if failed to complete in its entirety**

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| Date: | | | |
| Type of Accreditation: Pediatric Dentistry | | | Facility Class (check one only):  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.**  Primary: Secondary: Legal Business Name (not DBA name): Facility/Medical Director: Facility/Medical Director E-mail address: Name of office manager/head nurse:  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 | | | |
| Alternate Facility Name (if applicable): | | Type of Alternate Facility Name: Doing Business As Name  Other (Specify): | |
| Identify the type of organizational structure (Check one):  Sole Proprietor Business Corporation Limited Liability Company General Partnership  Registered Limited Liability Partnership Professional Corporation Professional Limited Liability Company University Faculty Practice Corporation (501(c)(3), not-for-profit) Other (Please Specify): | | | |
| Is the facility entirely physician owned (specify percentage that each physician owns):  Yes No | Please Note: Changes in facility ownership must be reported to the AAAASF Office within thirty (30) days. | | |

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| Name(s) of facility owner(s), controlling stockholder and/or beneficial ownership | |
| Name: | Name: |
| Address: | Address: |
| City, State, Zip: | City, State, Zip: |
| Telephone #: | Telephone #: |
| License Number: | License Number: |
| Percent of Business Owned: % | Percent of Business Owned: % |
| Name: | Name: |
| Address: | Address: |
| City, State, Zip: | City, State, Zip: |
| Telephone #: | Telephone #: |
| License Number: | License Number: |
| Percent of Business Owned: % | Percent of Business Owned: % |

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| **Facility State License Information**: License Not Applicable | | | | |
| License Number: | State Where Issued: | | | |
| Effective Date (mm/dd/yyyy): | Expiration/Renewal Date (mm/dd/yyyy): | | | |
| **Facility Location Information:** | | | | |
| Address Line 1: | | | | |
| Address Line 2: | | | | |
| City/Town: | | | State: | Zip: |
| Telephone Number: | | | Fax Number: | |
| Website Address: | | | E-mail Address: | |
| **Contact Person** -We will contact this person if questions arise during the processing of this application: | | | | |
| Contact Name: | | E-mail Address: | | |
| Telephone Number: | | Fax Number: | | |

**Physician/Dentist Name: Board Certification:** **State License Number:**

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| **1.** |  |  |
| Email address: | | |
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| **9.** |  |  |
| Email address: | | |
| **10.** |  |  |
| Email address: | | |

# Additionally, please submit the following documentation along with the completed application either by mail or fax to:

**AAAASF Office**

**7500 Grand Ave, Suite 200**

**Gurnee, IL 60031**

**Or**

**Fax: 847-775-1985**

* A floor plan or diagram of the facility clearly labeling rooms, including: Dental Room, Prep area, Clean area, Dirty area, etc. (does not need to be to scale and must clearly identify each room purpose and dimensions)
* Copy of each physician/dentist State Medical License
* Copy of each physician/dentist Board Certificate or letter of admissibility by the certifying board

# The following forms also need to be completed.

* + Completed HIPAA Business Agreement signed by Medical Director
  + Completed Anesthesia Validation Form
  + Authorization to Release Form completed and signed by each physician/surgeon
  + Facility Identification Form signed by Medical Director
  + Staff Identification Form
  + Facility Director’s Attestation signed by Medical Director



* *10% discount offered for AAPD members after the first year*

**Survey Fees for Pediatric Dentistry Accreditation**

$2,100 Survey Fee for any size facility or any class.

Facilities may request an expedited survey for an additional $500 (ask for details).

All credentials must be submitted and processed prior to survey.

Annual Fee (see schedule above): $ + $2,100 Survey Fee = Total amount of payment: $

# Payment by credit card

Submit your application via email to [info@aaaasf.org](mailto:info@aaaasf.org%20) or via fax to 847-775-1985. You may pay with a credit card over the phone by calling the accounting department directly at 888-545-5222.

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| Check type of credit card: | Visa | MasterCard | American Express |
| Name on card: |  |  | Card #: |

Billing zip code: Three-digit code: Exp. Date: Signature:

OR

# Payment by check

Submit completed application with supporting documentation and check made out to AAAASF.

AAAASF Office

7500 Grand Ave, Suite 200

Gurnee, IL 60031

***Fee and refund policy:***

*The first-year accreditation annual fee plus 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. After an application 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 will be refunded. If the accreditation process is not completed within one year of the received date, a new application and appropriate fee is required. No refunds will be issued if the application expires. Upon receiving accreditation and once an anniversary date is established, the facility will be invoiced 6 months prior to the anniversary date. Fees must be paid by the due date on the invoice for the accreditation process to begin. Otherwise, late fees will be applied and other penalties will follow.*