**AAAASF FACIILITY IDENTIFICATION FORM**

7500 Grand Avenue

Suite 200

Gurnee, IL 60031

**\_\_\_No Information Changes \_\_\_Information Changes Noted Below**

**Facility Class: \_\_CLASS A \_\_CLASS B \_\_CLASS C-M \_\_CLASS C**

**Facility Identification Number** ***(Check one)***

**Name of Facility**

**Name of Facility Director (DDS or DMD)**

**Name of Office Manager or Head Nurse**

**Address**  **Suite**

**City**  **State** **Zip**

**Phone** **Fax**

**Website**  **Email**

**Name of Facility Owner, Controlling Stockholder and/or Beneficial Ownership** *(List additional names on separate sheet)*

**Facility Licensure Date**

|  |
| --- |
| * **Not Previously Accredited by Other Accrediting Organization** * **Previously Accredited by Other Accrediting Organization**   **Name(s) of Other Organization:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Initial Inspection Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Class\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Last Re- Inspection Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Class\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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***Facility Director’s Signature*  Date**