

AAAASF/RHC
7500 Grand Ave, Suite 200
Gurnee, IL 60031

CLINIC IDENTIFICATION FORM

___ **No Information Changes**

___ **Information Changes Noted Below**

Clinic Identification Number

Name of Clinic

Name of Clinic Medical Director (must be at a minimum a medical staff)

Address

Suite

City

State

Zip

Phone

Fax

Website

Email

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

Clinic 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** _____

X

Clinic Medical Director Signature

Date