Facility Identification

Name of Facility: _____

□ Previously Accredited by AAAASF AAAASF Facility I.D. Number: ___ ___ ___ ___ Class: A B C-M C
(Circle One)

□ Information Changes Noted Below □ No Information Changes

Facility Director:_____

Address:_____ Suite:_____

City:_____ State:_____ Zip: _____

Phone (_____) _____ - _____ E-mail:_____

Fax (_____) _____ - _____ Website:_____

Name(s) of Facility Owner(s), Controlling Stockholder and/or Beneficial Ownership:_____

_____

(List additional names on separate sheet)

Operating Room Manager/Head Nurse: _____

FOR NEW APPLICANTS:

□ Not Previously Accredited by Other Accrediting Organization

□ Previously Accredited by Other Accrediting Organization Name of Organization:_____

Initial Inspection Date: _____ Class:_____

Last Re-inspection Date:_____ Class:_____

Other Accreditation: _____ Date:_____

Facility Licensure: _____ Date:_____

Facility Director's Signature: _____ Date_____