

AAAASF

7500 Grand Ave, Suite 200
Gurnee, IL 60031

FACILITY IDENTIFICATION FORM

___ **No Information Changes**

___ **Information Changes Noted Below**

Facility Identification Number

Facility Class: __ **CLASS A** __ **CLASS B** __ **CLASS C-M** __ **CLASS C**
(Check one)

Name of Facility

Name of Facility Director (must be M.D. or D.O.)

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** _____

X

Facility Director's Signature

Date