NJ AASC
New Jersey Association of Ambulatory Surgery Centers

FACILITY MEMBERSHIP APPLICATION

2017 Annual Dues: $1500.00

APPLICANT INFORMATION		
Name of Company:		
Web URL:	Phone:	E-mail:
Current address:		
City:	State:	ZIP Code:
Speciality:		

CONTACT PERSON		
Name:		
Address:		
Phone:	E-mail:	Fax:
City:	State:	ZIP Code:
Position:	Cell Phone:	

WHO REFERRED YOU	
Facility Name:	Contact Name:
Contact Phone Number:	Contact E-mail:

ADDITIONAL INFORMATION
Is facility licensed by the NJ Department of Health: _____Yes _____No
Is facility Medicare-certified: _____Yes _____No

CREDIT CARD INFORMATION		
Credit Card Name:		
Billing Address:		Phone:
Card #:	Expiration Date:	Code:
Name on Credit Card:		

SIGNATURES	
I authorize the verification of the information provided on this form as to my credit and employment. I have received a copy of this application. I approve of the credit card	
Signature of applicant:	Date:
Pursuant to IRS Code Section 6033(e), NJAASC hereby provides notice that 17% of membership dues will be allocated to lobbying activities in 2017.	

Please make check payable to:
NJAASC, Attn: Kelly Biddle, 414 River View Plaza, Trenton, NJ 08611