Application for Membership

(Please type or print)

Name (First, MI, Last) :_____ Nickname : _____

Title :_____ Year Appointed :_____ Credentials : _____

Employer / Group Name : _____

Business Address : _____

Business City : _____ State : _____ Zip Code (9-digit) : _____

Business Phone – Voice : ( )_____ Fax : ( ) _____

E-Mail Address : _____

Type of ASC (SS – single specialty, MS – multi specialty) : ___ # of Employees (full or part time) : ___

Specialty (if single specialty) : _____ Physician-owned (PO) or Management Partner (MP): ___

Brief explanation of you r duties _____

_____

_____

MEMBERSHIP CATEGORY APPLIED FOR:

_____ Surgery Center Professional: An individual member who is a physician or staff member of a licensed Kansas Ambulatory Surgery Center.

_____ Industry Specific Entity Professional: An individual member who is a professional employed by, or is an officer of, an entity which is directly involved with the management and/or operation of licensed surgery centers in Kansas.

Any member in good standing whose dues are paid current has the privilege of holding office. However, there is only one voting member from each represented Ambulatory Surgery Center or Industry Specific Entity. Please indicate if you are the voting member from your entity.

____ Voting Member _____ Non-voting Member

Applicant Signature : _____Date : _____

Please attach a check payable to KAASC: $250.00

MAIL TO:

Claire Daniels, Executive Assistant
5051 E. Lincoln, #4C
Wichita, KS 67218
Phone: (316) 686-4414
E-Mail: cdaniels1@cox.net

Approved (Y/N): _____ Date : _____ By : _____