



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 your 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 : _____

I learned about KAASC from: _____

Practice: _____

Please attach a check payable to KAASC: \$250.00; Cost for additional members from the same facility \$125.

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 : _____