FACILITY MEMBERSHIP APPLICATION
2023 ANNUAL DUES: $1600.00

PRIMARY CONTACT		
Company Name:	Speciality:	
Website:	Phone:	Email:
Address:		
City:	State:	Zip:
ADDITIONAL EMPLOYEE EMAILS		
Name:	Email:	
Name:	Email:	
WHO REFERRED YOU		
Company Name:	Contact Name:	
Contact Phone:	Contact Email:	
ADDITIONAL INFORMATION		
Is facility licensed by the NJ Department of Health:	Yes	No
Is facility Medicare-certified: Yes No	How many OR/PROC. rooms:	
Type of business:	Facility Accreditation:	
% Physician Owned	% Hospital Owned	
% Management Company	% Other	
MEDICAL DIRECTOR/FACILITY OWNER		
Name:	Phone:	Email:
PAYMENT TYPE		
I'd like to pay by credit card	I'd like to request an invoice	
CREDIT CARD INFORMATION		
Credit Card Type:		
Billing Address:		
Card #:	Exp. Date:	Code:
Name on Card:		
SIGNATURE		
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.		
Applicant Signature:	Date:	
Pursuant to IRS Code Section 6033(e), NJAASC hereby provides notice that 17% of membership dues will be allocated to lobbying activities in 2023.		

Please make check payable to:
NJAASC, Attn: Kristen Stone, 100 S. Jefferson Rd. Suite 204,
Whippany, NJ 07981