

## FACILITY MEMBERSHIP APPLICATION

Name of Facility: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Web Address: \_\_\_\_\_

**PERSONNEL (The staff members listed below will be assigned a user name and password for access to the CASA website)**

Administrator: \_\_\_\_\_ Email: \_\_\_\_\_  
 Nursing Director: \_\_\_\_\_ Email: \_\_\_\_\_  
 Medical Director: \_\_\_\_\_ Email: \_\_\_\_\_  
 Business Manager: \_\_\_\_\_ Email: \_\_\_\_\_

Please check here if you wish to **opt-out** of the email broadcasts.

Were you referred to CASA by someone? Please list them below:  
 \_\_\_\_\_

**PLEASE COMPLETE THE FOLLOWING:**

**LEGAL TYPE (check all that apply)**

- Business Corporation \_\_\_\_\_ % Owned by Physicians  
 Physician Partnership \_\_\_\_\_ % Owned by Hospital  
 Hospital or Health System Affiliated \_\_\_\_\_ % Owned by Other

**FACILITY TYPE**

**FACILITY INFO**

- Freestanding \_\_\_\_\_  
 Physician Office-Based \_\_\_\_\_  
 Number of Operating Suites \_\_\_\_\_  
 Annual Number of Surgeries \_\_\_\_\_  
 Year Opened \_\_\_\_\_

**FACILITY SPECIALTY (Please complete for our records)**

- Multi-Specialty  
 Single Specialty (**please list**): \_\_\_\_\_

**PROOF OF CERTIFICATION REQUIRED**

**MEMBERSHIP REQUIREMENT**

Please provide a copy of one of the following certificates with your application:

- CA State License #: \_\_\_\_\_  
 Medicare Certified #: \_\_\_\_\_  
 AAAASF  AAAHC  IMQ  
 The Joint Commission  HFAP

Membership fees are due upon joining.

Renewals are pro-rated and billed for annual January payment.  
 Membership dues are not tax deductible.

**ANNUAL MEMBERSHIP FEE SCHEDULE**

- FACILITY Membership**  
 1 Operating Room ..... \$700  
 2-3 Operating Rooms ..... \$900  
 4+ Operating Rooms ..... \$1125
- CORPORATE FACILITY Membership**  
 Companies with **4-9 centers** in CA that are CASA members ..... \$850/center  
 Companies with **10+ centers** in CA that are CASA members ..... \$800/center

Please indicate name of corp ownership/management: \_\_\_\_\_

Voluntary PAC contribution:  \$8,100  \$2,500  \$1,000  Other \$ \_\_\_\_\_

If you are unable to contribute to the CASA PAC fund please consider contributing to the following options:

- PAC Issues Fund  Advocacy Fund

PAC Contribution Rules: Corporate/Company can contribute \$8,100 per calendar year. If individual owns 50% or more of the contributing company, the individual's personal contribution and the company's contribution cannot total more than \$8,100. PAC contributions can only be used for campaign contributions. These funds cannot be used to pay for lobbying efforts (TDG Strategies). Contributions are not tax deductible.

**PLEASE MAKE YOUR CHECK PAYABLE TO CASA and MAIL CHECK OR CREDIT CARD INFORMATION, APPLICATION and CERTIFICATE TO:**

CASA • PO Box 292698 • Sacramento, CA 95829  
 Fax: 1-844-273-8336 | Email: membership@casurgery.org  
 Questions: 209-384-1640

**PROOF OF CERTIFICATION/ACCREDITATION REQUIRED**

**Method of payment (Note: VISA/MC/AMEX or check ONLY)**

MC/VISA/AMEX#: \_\_\_\_\_ Exp Date: \_\_\_\_\_

Name on card (please print clearly): \_\_\_\_\_

Signature: \_\_\_\_\_