



2020 MEMBERSHIP APPLICATION

Name of Facility _____

Address of Facility _____

City/State/Zip Code _____

Telephone _____ Website _____

Owner(s): _____

___ % owned by doctors

___ % owned by hospital

___ % owned by others

Accreditation and Certification

___ AAAHC

___ AAAASF

___ The Joint Commission

___ Medicare, if so, Medicare # _____

State Licensure

___ Licensed, if so license # _____

___ Exempt

Facility Type

___ Single Specialty _____

___ Multi-Specialty _____

Please update the email addresses for the positions noted at your ASC facility. As a WASCA member, all employees have access to the member listserv. If there are additional employees who would like to receive an invitation to join the listserv, please contact info@wasca.net.

Administrator _____

Email _____

Business Manager _____

Email _____

Clinical Director _____

Email _____

Materials Manager _____

Email _____

Medical Director _____

Email _____

Facility & Professional Membership Fee Schedule*

- 2,500 or more cases per year per center \$1,996.50
- 1,000 or more cases per year per center \$1,331.00
- 500 or more cases per year per center \$998.25
- ASC Not Yet Operational \$465.85
- Single Physician Owned Center \$465.85
under 500 cases per year
- Single Physician \$465.85
- Professional Membership \$665.50

**New members receive a 50% discount
the first year of membership.**

Fees are due upon joining and are billed annually.

*Pursuant to IRS code section 6033(e), WASCA hereby provides notice that 60% of membership dues will be allocated to lobbying activities in 2020.

Please make your check payable to: WASCA

Mail check and application to:

WASCA
P.O. Box 3345
Bellevue, WA 98009

Administrative Use Only

Check # _____

Amount \$ _____

Date Rec'd _____