

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:

OWNERSHIP

_____ % Owned by Physicians
_____ % Owned by Hospital/Health System
_____ % Owned by Other

SPECIALTY

(Please complete for our records)

Multi-Specialty
 Single Specialty **(please list):** _____

FACILITY INFO

Number of Operating Suites _____
Annual Number of Surgeries _____
Year Opened _____

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 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: _____

PAC CONTRIBUTION

The **CASA PAC** is the **ONLY** political giving vehicle **SPECIFICALLY** focused on **ASC** issues in California. PAC funds raise **CASA's** name identification and recognition at the State Capitol and amongst the Legislature. There is strength in unity and numbers, and making various contributions to key individuals on behalf of **CASA** places and keeps our name at the forefront of healthcare-related discussions. Your contribution is critical to our industry success and our ability to be proactive in the political arena.

Voluntary PAC contribution:

- \$8,100 \$2,500 \$1,000 \$500 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.

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

CC#: _____ Exp Date: _____

Name on card (please print clearly): _____

Signature: _____

PLEASE MAKE YOUR CHECK PAYABLE TO CASA and MAIL CHECK OR CREDIT CARD INFORMATION, APPLICATION and PROOF OF CERTIFICATION TO:

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