



Membership Application

Covers period January through December
Date of Submission: _____

- Facility New Members (Half Price \$1,000)
- Facility Renewal (Full Price: \$2,000)
- Auxillary or Provisional New Members (facility in development)
Jan. - Dec. \$1,000 / Apr. - Dec. \$750
July. - Dec. \$500 / Oct. - Dec. \$250
- Auxillary or Provisional Renewal (Full Price: \$1,000)

Facility Administrator or Auxillary Member Representative

Last Name _____ First Name _____ Initial _____
 Title/Position _____ Degrees _____
 Facility/Company Name _____
 Street Address _____ Suite _____
 City _____ State _____ Zip Code _____
 Phone (____) _____ Email _____
 Fax (____) _____ Website _____
 Cell (____) _____ Home (____) _____
 Provisional: When will your facility be completed? _____

Medical Director (Please complete in full: Required in addition to administrator representative information)

Last Name _____ First Name _____ Initial _____
 Title/Position _____ Degree(s) _____
 Phone (____) _____ Email _____
 Fax (____) _____ Cell (____) _____

License/Accreditation Information

State License Number _____
 Is your facility certified by Medicare to be reimbursed as an ASC? Yes No
 Medicare Certification Number _____
 Is your facility accredited by AAAHC JCAHO AAAASF AOA
 Is your facility Independently Owned Hospital Owned
 Corporate Owned Hospital/Physician Joint Venture
 Other (specify) _____
 How many operating rooms are in your facility? _____

To better serve you, please note which of the following topics are of interest to you:

- Benchmarking
- Legislative Issues
- Regulatory Issues
- Networking
- Political Action Committee (PAC)



Facility Membership Renewal	\$2,000	\$ _____
Facility New Member	\$1,000	\$ _____
Provisional Membership (1 Year)	\$1,000	\$ _____
Auxillary Renewals	\$1,000	\$ _____
Provisional/Auxillary New Member (dues by quarter)		\$ _____
PAC Contribution (Suggested \$2,000*)		\$ _____
Total Amount Enclosed		\$ _____

*Alternate payment schedule available for PACs.

Mail this completed, signed application with your check made payable to MASCA to:
MASCA Central Office
PO Box 1556
Jefferson City, MO 65102

DATE _____

SIGNATURE OF APPLICANT _____

New Members: Acceptance of this application is subject to approval by the Board of Directors.
 If you have questions about this application, please call the central office at (573) 635-6044.