oASC Accreditation Model – Project

BETA Test Group Interest Form

We are delighted that you want to participate in the Beta Test Group! Please fill in the following information.

FACILITY IDENTIFYING INFORMATION:

Legal name of the facility:	

Address: _____

City, State, Zip: _____

County: _____

Phone:	( )	-	←***This must be the main phone # at the facility.***
Fax number:	( )	-	←***This must be the main fax # at the facility.***

Email address: _____ **Website** _____

*** Include all alternate names of your facility such as "dba's" (doing business as) or names commonly used by the public.*

Individual Responsible for facility: _____
(CEO, Sole Physician, etc.):

Title:_____

EXAMPLE: CEO, MEDICAL DIRECTOR

Facility contact person. This individual will be the contact for IMQ correspondence and communications related to the BETA Test Group, application materials, and the accreditation process.

Contact person: _____ Title: _____

E-mail: _____ Address (if different): _____

Phone (required): _____ Fax (required): _____

DOES YOUR FACILITY PARTICIPATE IN MEDICARE? ☐ Yes ☐ No

Please indicate ownership structure: ☐ 100% Physician owned. How many partners? _____

☐ Other: _____

Management Structure: ☐ Internal ☐ Contracted Services

☐ Other: _____

FACILITY TYPE (select one only):

☐ Ambulatory Surgery Center ☐ Office-based Surgery Center ☐ Other_____

FACILITY SPECIALTY:

☐Ophthalmology ☐ Multi-specialty ☐ Other

_____

Please indicate all licenses and accreditations that apply to your facility. (i.e., not for practitioners.)

	Never	Previously	Currently	Expiration Date (mm/dd/yy)
Licensed by the state Department of Public Health	☐	☐	☐	
Certified by Medicare	☐	☐	☐	
Joint Commission Accredited/Deemed	☐	☐	☐	
AAAHC Accredited/Deemed	☐	☐	☐	
AAAASF Accredited/Deemed	☐	☐	☐	
Other _____	☐	☐	☐	

How many ophthalmic surgeons practice at the facility? _____

Your facility utilizes: _____ number of operating rooms _____ number of recovery rooms

How many procedures per month (average) does your facility perform? _____

Signature of Owner
or Medical Director: _____ Date: _____

Print Name: _____ Title: _____

PLEASE E-MAIL or FAX TO:

Victoria Samper, MS
VP, Ambulatory Accreditation Programs
INSITUTE FOR MEDICAL QUALITY
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THANK YOU