AMRPA MEMBERSHIP APPLICATION FOR OUTPATIENT PROVIDERS

*Name of Contact: ________________________________ Title: ______________________________

*Contact E-mail Address: ______________________________ Telephone: ______________________

Name of Organization: ____

Address: _______________________________________ Web Site Address: _____________________

City, State, Zip Code: __________________________________ Fax: ___________________________

Name of Administrator: ____

Name of Medical Director: ____

Is Organization Part of a Healthcare System: Yes ____ No ____

Name of System: ____

Medicare Provider Number: ____

* = Person named as contact will receive the AMRPA monthly magazine and weekly *Off The Record* electronic newsletter unless otherwise specified.

**Total Number of Outpatient Therapy Visits: ____

**Total Rehab Salaries Amount: ____

** = For most recent fiscal year.

Signature: ____ Date: ________________________

Thank you for your support of AMRPA! Please return to: AMRPA, 206 South 6th Street, Springfield, IL 62701 or fax this form back to (217) 525-1271. Questions? Please call Maggie Ramirez at (347) 573-3732.