



AMRPA MEMBERSHIP APPLICATION FOR HOSPITAL SYSTEM MEMBERSHIP

*Name of Contact: _____ Title: _____

*Contact E-mail Address: _____ Telephone: _____

Name of Hospital System: _____

Address: _____ Web Site Address: _____

City, State, Zip Code: _____ Fax: _____

Name of CEO: _____

Name of Chief Operating Officer: _____

Name of Rehab Administrator: _____

Name of Medical Director: _____

Please identify each system site where rehab beds are operated:

| Facility Name: | Address: | Medicare Provider #(s): | * # of Rehab Beds: |
|----------------|----------|-------------------------|--------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

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

**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.