



AMRPA MEMBERSHIP APPLICATION FOR HOSPITAL/UNIT MEMBERSHIP

*Name of Contact: _____ Title: _____

*Contact E-mail Address: _____ Telephone: _____

Name of Hospital: _____

Address: _____ Web Site Address: _____

City, State, Zip Code: _____ Fax: _____

Name of Chief Executive Officer: _____

Name of Chief Operating Officer _____

Name of Medical Director: _____

Name of Rehab Administrator: _____

Check Type of Hospital: Freestanding Rehab ___ LTACH ___ General Acute Care ___

**Total # of Acute Medical Rehabilitation Beds: _____ **Average Daily Census: _____

**Total # of LTACH beds: _____ **Total # of SNF beds: _____

**Total Number of Outpatient Therapy Visits _____

Is Hospital Part of a System?: Yes _____ No _____

Name of System: _____

Hospital Medicare Provider Number: _____

* = 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.