



## 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.*