AAAASF/RA
5101 Washington Street
P.O. Box 9500
Gurnee, IL 60031

CLINIC IDENTIFICATION FORM

___No Information Changes **___Information Changes Noted Below**

_____
Clinic Identification Number

Name of Clinic

Name of Clinic Administrator (must hold at a minimum a Bachelors degree)

Address **Suite**

City **State** **Zip**

Phone **Fax**

Website **Email**

Name of Clinic Owner, Controlling Stockholder and/or Beneficial Ownership *(List additional names on separate sheet)*

Clinic Licensure **Date**

☐ **Not Previously Accredited by Other Accrediting Organization**

☐ **Previously Accredited by Other Accrediting Organization**

Name(s) of Other Organization:_____

Initial Inspection Date_____**Class**_____

Last Re- Inspection Date_____**Class**_____

X_____
Clinic Administrator's Signature **Date**