

AAAASF/RA
7500 Grand Ave, Suite 200
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 Bachelor's 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