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## Authorization Form

Facility # \_\_\_\_\_

Facility Name \_\_\_\_\_

• Medical Director

• Data Entry

*(Circle one of the above)*

New Administrator:

First Name \_\_\_\_\_

Phone \_\_\_\_\_

Middle \_\_\_\_\_

Last \_\_\_\_\_

Suffix \_\_\_\_\_

Email \_\_\_\_\_

I authorize this individual to be added as facility administrator.

\_\_\_\_\_  
Medical Director Name

\_\_\_\_\_  
Medical Director Signature

\_\_\_\_\_  
Date

Fax: 847-775-1985

Email: Peer Review Helpdesk <helpdesk@aaaasf.org>

Mail: AAAASF, 7500 Grand Ave, Suite 200, Gurnee, IL 60031