



AAAHC Institute for Quality Improvement
 5250 Old Orchard Rd., Suite 200
 Skokie, IL 60077
 Phone 847-853-6078
 Fax: 847-853-6118

2018 July-December AAAHC Institute Study Registration Form

Please complete this form and email it to mchappell@aaahc.org once processed, you will receive a confirmation email with further instructions.

Your Name: _____

Organization Legal Name: _____/DBA _____

If Accredited with AAAHC Organization ID# _____

Organization Type:

ASC ___ Medicare Deemed Status yes ___ no ___
 Are you a CQA organization? yes ___ no ___ If yes, who is your Parent Organization _____

OBS ___

Primary Care ___ SHS ___ IHS ___ Other _____
 Part of a network? yes ___ no ___ If yes, what is the network name? _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____ E-Mail: _____

(required for report delivery)

AAAHC Institute Studies	Quantity	Price for AAAHC Accredited Organizations	Price for Non-Accredited Organizations
Cataract Extraction with Lens Insertion July-December 2018		\$500.00	\$600.00
EGD July-December 2018		\$500.00	\$600.00
Low Back Injection July-December 2018		\$500.00	\$600.00
Safe Injection Practices July-December 2018		\$500.00	\$600.00
Shoulder Arthroscopy July-December 2018		\$500.00	\$600.00
NO RETURNS OR EXCHANGES			
	Total	\$	\$
Complimentary Study Code (if applicable)			
(payment information not required if you are using a complimentary code)			

Method of Payment (Check One): Check/Money Order (made payable to "AAAHC Institute") or,
 Visa Master Card American Express Discover

Credit Card #: _____ Expiration: _____ CVV: _____

Print Cardholder's Name: _____

I agree to pay total amount according to card issuer agreement.

Signature: _____

Invoice Me (invoice will be emailed to the contact name above, materials and instructions will be sent upon receipt of payment).