



5900 South Western Avenue, Suite 102 Sioux Falls, SD 57108

Phone: (605) 275-5349; Fax: (605) 731-2575

Email: info@physicianhospitals.org Web: www.physicianhospitals.org

Facility Membership Invoice and Application
Dues to be paid annually by March 15

Check the Membership Level That You Are Applying For:

Facility Membership **\$ based on case volume**

This Membership is available to physician owned hospitals. The dues formula for this membership is based on case volume, including inpatient, outpatient and pain cases from January to December of the previous calendar year - with a \$4,000 minimum and \$20,000 maximum membership fee. Members shall receive full benefits and one vote.

Please use the following formula to calculate your facility's member dues:

Case volume in previous calendar year

(Inpatient, outpatient and pain cases from January to December) _____

Multiply x \$2.00

Dues Total _____

(Minimum \$4,000; Maximum \$20,000)

Facility Membership Under Development Through First Year of Business **\$ 2,000**

This Membership is available to physician groups considering development, facilities that are under development, ASC's considering conversion or in the process of converting and new facilities in their first year of business. Members shall receive full benefits and one vote.

Associate/Trial Membership **\$ 2,500**

This Membership is available to hospitals or ambulatory surgery centers that would like to contribute to PHA, but do not wish to become a full Facility Member. This trial membership is for one year only and is a non-voting membership. Members shall receive full benefits granted on a temporary basis.

Payment Information

Please make check payable to PHA.

Send application and payment directly to:

Physician Hospitals of America
5900 South Western Avenue, Suite 102
Sioux Falls, SD 57108

Or provide credit card information below and fax this form to (605) 731-2575

Visa MC American Express Discover Credit Card # _____ Expiration Date: _____

Please charge my card: \$ _____

Cardholders Name: _____ Cardholders Signature: _____

Pursuant to the 1993 Omnibus Reconciliation Act, the Physician Hospitals of America has estimated that the non-deductible portion of your dues for lobbying expenses is 50%. The remaining portion of your dues may be deducted as an ordinary and necessary business expense. Taxpayer ID is **770556575**.

Facility Membership Application

Facility Name _____ Website _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

Please check which best describes your facility

Existing Hospital -- if existing – list year your hospital opened _____

Hospital under construction

Hospital in first year of business

ASC interested in converting to Hospital

Facility Type

General Acute Multi-Specialty Single Specialty Rehab Other

Total Number of Beds _____ Total Number of ORs _____ Total Number of Square Feet _____

Emergency Room Yes No If yes, number of ER patient visits in 2008 _____

Specialty(ies): (Please list in %)

% _____ Ophthalmology	% _____ Urology	% _____ Plastic Surgery	% _____ General Surgery
% _____ Orthopaedics	% _____ Pain	% _____ Gastroenterology	% _____ ENT
% _____ Spine	% _____ Rehab	% _____ Podiatry	% _____ Oral Surgery
% _____ _____	% _____ _____	% _____ _____	% _____ _____

Ownership Type: (Please list as a percent to total 100%)

% _____ Physician % _____ Corporate % _____ Hospital % _____ Individual % _____ Other % _____ Public

If Joint Ventured, Name of Corporate or Hospital Partner _____

Number of Physician Investors _____ Total Credentialed Physicians _____

Licensure/Accreditation Joint Commission Medicare State Licensed Other _____

Please list contact(s) at your Facility to be included in PHA's membership. Most of PHA's communications are by email.

	Name	Title	Email	Phone
Administrator/CEO				
Medical Director				
DON/Nurse Manager				
CFO				
Quality Assurance				
Government Relations				
Physician				
Other				
Other				



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