



## Quality Assurance Report

Agency name: \_\_\_\_\_ Agency ID number: \_\_\_\_\_

Name of person completing report: \_\_\_\_\_ Date of report: \_\_\_\_\_

Since your last report, check any of the following that have occurred: (attach a separate sheet if needed)

Providers had their clinical activities restricted. If so, list names, brief description of the issue(s), and a brief description of the remediation plan for each.

Providers were returned to full clinical activities after completion of a remediation plan. If so, list names and dates of completion of remediation plan.

Changes in leadership. If so, describe briefly.

Incidents involving more than 3 simultaneous patients. If any, provide dates and the name of the provider who was in command.

Notable mishaps (with patients, personnel, equipment, vehicles). If any, describe briefly, including dates, consequences, and how they were handled. Include actual mishaps and "near misses".

Quality assurance topics studied by the Agency. If any, list topics, outcomes and conclusions.

**OR**

None of the above have occurred since our last report.

\_\_\_\_\_  
Signature of Agency Chief

\_\_\_\_\_  
Signature of Agency Medical Director

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**CONFIDENTIAL - QUALITY MANAGEMENT MATERIALS**

Protected by NYS Ed. Law 6527 & Public Health Law 280-5m \* No Re-Disclosure of Information Allowed

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