600 Central Ave. Ste 265 | Highland Park, IL 60035
(direct) 847.775.1970 | (fax) 847.775.1985
info@QuadA.org

Medical Director's Attestation

The Medical Director must ensure and attest that the facility meets all local, state, and federal regulations, since such governmental regulations may supersede QUAD A Standards. Please note, however, that the stricter regulation applies, whether it is the federal, state, or local regulation, or the QUAD A standard.

Please complete and sign the following document and return to the QUAD A office:

MEDICAL DIRECTOR'S ATTESTATION

As Director of the (name of facility) _____,

located at _____, I attest that this facility meets all applicable local, state, and federal zoning and construction codes and regulations, including Certificate of Need requirements, as mandated. I further acknowledge that wherever governmental regulations or codes supersede QUAD A Standards, the stricter rule is applicable, whether it is the local, state, federal regulation or code or QUAD A Standard. Furthermore, I authorize QUAD A to release accreditation reports and corrective action plans to the state Board or Federal government upon request.

_____ _____

Medical Director Date

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Facility Identification Form

Facility Identification Number

Facility Class: ☐ **CLASS A** ☐ **CLASS B** ☐ **CLASS C-M** ☐ **CLASS C**
(Check one)

Name of Facility

Name of Facility Director (must be MD or DO) **Email**

Name of Office Manager or Head Nurse **Email**

Address **Suite**

City **State** **Zip**

Phone **Fax**

Website **Billing Email**

Name of Facility Owner, Controlling Stockholder and/or Beneficial Ownership *(List additional names on separate sheet)*

Facility State Licensure (If Applicable) **Date**

For new applicants only:

- ☐ **Not Previously Accredited by Other Accrediting Organization**
- ☐ **Previously Accredited by Other Accrediting Organization**

Name(s) of Other Organization:

Initial Survey Date **Class**

Last Re-Survey Date **Class**

X

Medical Director's Signature **Date**

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Current Staff Identification Form

Please list all practitioners performing any procedures in the facility

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Name of Practitioner (Please Indicate Credentials – MD, DO, DDS, DMD)

State License # **Specialty(s)**

Certifying Board **Year Certified or Year Eligible**

Local Accredited or Licensed Acute Care Hospital Where Doctor Has Current Admitting Privileges (if applicable)

Department or Section

Has or has held unrestricted privileges in their specialty at an accredited or licensed acute care hospital within 30 minutes of this facility for all procedures that they perform at this facility?

- ☐ No
- ☐ Yes_____
  List Hospital(s)

Name of Practitioner (Please Indicate Credentials - MD, DO, DDS, DMD)

State License # **Specialty(s)**

Certifying Board **Year Certified or Year Eligible**

Local Accredited or Licensed Acute Care Hospital Where Doctor Has Current Admitting Privileges (if applicable)

Department or Section

Has or has held unrestricted privileges in their specialty at an accredited or licensed acute care hospital within 30 minutes of this facility for all procedures that they perform at this facility?

- ☐ No
- ☐ Yes_____
  List Hospital(s)

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Name of Practitioner (Please Indicate Credentials – MD, DO, DDS, DMD)

State License # **Specialty(s)**

Certifying Board **Year Certified or Year Eligible**

Local Accredited or Licensed Acute Care Hospital Where Doctor Has Current Admitting Privileges (if applicable)

Department or Section

Has or has held unrestricted privileges in their specialty at an accredited or licensed acute care hospital within 30 minutes of this facility for all procedures that they perform at this facility?

- ☐ NO
- ☐ YES_____
  List Hospital(s)

Name of Practitioner (Please Indicate Credentials - MD, DO, DDS, DMD)

State License # **Specialty(s)**

Certifying Board **Year Certified or Year Eligible**

Local Accredited or Licensed Acute Care Hospital Where Doctor Has Current Admitting Privileges (if applicable)

Department or Section

Has or has held unrestricted privileges in their specialty at an accredited or licensed acute care hospital within 30 minutes of this facility for all procedures that they perform at this facility?

- ☐ No
- ☐ Yes_____
  List Hospital(s)

Self-Survey Attestation

As [Director/Administrator] of this facility, I attest that this facility meets all applicable local, state, and federal laws, regulations, rules, and codes ("Applicable Law"), including zoning and construction codes and regulations and Certificate of Need requirements. I further acknowledge that wherever Applicable Law differs from QUAD A Standards, the stricter is applicable, whether it is the Applicable Law or the QUAD A Standard. Wherever Applicable Law conflicts with QUAD A Standards, the Applicable Law supersedes the QUAD A standard. In other words, if the Applicable Law *expressly prohibits* the action the QUAD A standard requires, the Applicable Law will supersede the QUAD A standard.

In compliance with QUAD A's requirement for a self-survey to be conducted annually between routine onsite surveys conducted by QUAD A Surveyors (Standard 1-B-8), I further attest that our staff has conducted a thorough self-assessment of our facility based on:

- all applicable QUAD A standards according to the program in which we are enrolled using the checklist provided,
- the anesthesia class (as applicable),
- any geographically specific standards, and
- any other standards implementation that applies to our facility.

I also attest that we have compiled a comprehensive "Accreditation File" (including accurately recorded determinations of compliance with each standard, completed plans of corrective action based on our self-assessment, and documented evidence of corrections for any citations) and incorporated our findings and lessons learned into our quality assurance and quality improvement process. We will maintain a copy of the complete Accreditation File for a minimum of 3 years and make the same available to QUAD A surveyors at any onsite surveys.

Furthermore, I authorize QUAD A to release accreditation reports and corrective action plans to the state competent government authority for the jurisdiction(s) in which this facility is located upon request.

_____ _____

Medical Director Name (Print) Facility ID#

_____ _____

Medical Director Signature Date