QUAD A
GLOBAL ACCREDITATION AUTHORITY
Patients First. Always.

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info@QuadA.org

OPT Clinic Identification Form

Clinic Identification Number

Name of Clinic

Name of Clinic Administrator **Email**
(must hold at a minimum a Bachelor's degree)

Address **Suite**

City **State** **Zip**

Phone **Fax**

Website **Billing Email**

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

Clinic 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

Clinic Administrator's Signature **Date**