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

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**