



600 Central Ave. Ste 265 | Highland Park, IL 60035

(direct) 847.775.1970 | (fax) 847.775.1985

info@QuadA.org

**Clinic Administrator’s Attestation**

The Clinic Administrator 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:

**CLINIC ADMINISTRATOR’S ATTESTATION**

As Clinic Administrator of the (name of clinic) \_\_\_\_\_,  
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.

\_\_\_\_\_  
Clinic Administrator Signature

\_\_\_\_\_  
Date



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## OPT Clinic Identification Form

\_\_\_\_\_  
**Clinic Identification Number**

\_\_\_\_\_  
**Name of Clinic**

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

\_\_\_\_\_  
**Email**

\_\_\_\_\_  
**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**

### Current OPT Staff Identification Form

Please list all practitioners in the Clinic (Full Time/Part Time/PRN)

<hr/>	
<b>Name of Clinician (Please Indicate Credentials – PT, PTA, OT, OTA, SLP, SLP-A)</b>	
<hr/>	<hr/>
<b>State Medical License #</b>	<b>Hrs/Week</b>

<hr/>	
<b>Name of Clinician (Please Indicate Credentials – PT, PTA, OT, OTA, SLP, SLP-A)</b>	
<hr/>	<hr/>
<b>State Medical License #</b>	<b>Hrs/Week</b>

<hr/>	
<b>Name of Clinician (Please Indicate Credentials – PT, PTA, OT, OTA, SLP, SLP-A)</b>	
<hr/>	<hr/>
<b>State Medical License #</b>	<b>Hrs/Week</b>

<hr/>	
<b>Name of Clinician (Please Indicate Credentials – PT, PTA, OT, OTA, SLP, SLP-A)</b>	
<hr/>	<hr/>
<b>State Medical License #</b>	<b>Hrs/Week</b>

<hr/>	
<b>Name of Clinician (Please Indicate Credentials – PT, PTA, OT, OTA, SLP, SLP-A)</b>	
<hr/>	<hr/>
<b>State Medical License #</b>	<b>Hrs/Week</b>

## 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.

\_\_\_\_\_  
Director/Administrator Name (Print)

\_\_\_\_\_  
Facility ID

\_\_\_\_\_  
Director/Administrator Signature

\_\_\_\_\_  
Date