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

Form Last Updated 3/6/2025

Facility Identification Number

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

Name of Facility **DBA**

Name of Medical Director (must be MD, DO, DPM, DMD, or DDS) **Email Address of Medical Director (Required)**

Address **Suite**

City **State** **Zip Code**

Phone **Fax**

Billing Contact Name (only receives Invoice emails) **Billing Contact Email Address**

Facility Owners, Controlling Stockholders and/or Beneficial Ownership (Include Percentages) *(List additional names on separate sheet)*

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

Website

Facility Contacts that need to be included in all QUAD A correspondences:

Full Name **Email Address**

Full Name **Email Address**

Full Name **Email Address**

X

Medical Director's Signature **Date**

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Current Staff Identification Form

Please list all Physicians performing procedures in the facility

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

State Medical License # **Certifying Board** **Specialty(s)**

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

State Medical License # **Certifying Board** **Specialty(s)**

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

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

State Medical License # **Certifying Board** **Specialty(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