Institute for Medical Quality

Ambulatory Accreditation
Accredited Facility Update Form

All IMQ accredited organizations are required to notify IMQ 30 days in advance of any change in the organization, except for circumstances where advance notification is not possible. Changes that must be reported include, but are not limited to, change in ownership or control, organizational structure, management, facilities, capacity, scope of services offered, clinical staff, name, and/or location. Failure to notify IMQ of changes can result in loss of accreditation.

INSTRUCTIONS

1) This form is to be utilized for any changes to the accredited practice as indicated below.
2) Please include complete and specific attachments and explanations for all items checked below.
3) Please fax this form to: (415) 882-5149 or send to: **IMQ Ambulatory Program, 180 Howard Street, Suite 210, San Francisco, CA 94105** or e-mail to John Castello jcastello@imq.org. Feel free to contact the Ambulatory Program at (415) 882-5172 if you have any questions.

Legal name of facility:	
Facility ID #:	← Indicate your organization's five-digit ID # here, found on your certificate.
Alternate name(s):	
Address:	
Phone number:	
Fax number:	
E-mail address:	

The organization named above is reporting a change to the following areas. (Check *all* that apply) Please include attachments for all items.

- ☐ Change in ownership, ownership structure, management, or organization name. Please include name of owners, effective date of ownership, license of physician owners, and complete address of owners.
- ☐ Change in facilities, facility location, facility equipment, addition or removal of satellite offices, etc.
- ☐ Additions or removals, or other change to licensed clinical staff. (This would include most all designations, doctors, nurses, PAs, etc. This does not include un-licensed staff, such as scrub techs.)
- ☐ Change in status of a particular provider, which may include state Medical Board actions, restrictions or accusations, or other changes to state license/registration, DEA, board certification, hospital privileges or liability insurance.
- ☐ Additions, removals or other change to the scope or types of procedures/services/anesthesia offered.
- ☐ Change to the organizations hospital transfer agreement or admitting privileges for physicians.
- ☐ Other: _____

The information contained in this form (and attachments) represents all changes to our organization. This information is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. The person executing this agreement expressly represents and warrants that he or she has the authority to execute this agreement on behalf of the organization.

Signature of owner: _____ Print Name: _____

Title: _____ Date: _____