QUALITY ASSESSMENT PLAN

NORTH WEST PRIMARY CARE

GENERAL FORM

System or Process Reviewed: ______________________________

Frequency of Review: ______________________________

Method of Review: ______________________________

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Minimum Acceptable Score: ____________________

Date of Review: ____________________

Person performing Review: ____________________

Measured Parameters	Acceptable	Not Acceptable	Comments

Summary and Analysis of Findings:

Corrective Action to be Taken:

Approximate Date Corrective Action will be completed: ____________________

Signature of Laboratory Director: ______________________________

Results of Follow-Up Review/Further Corrective Action Necessary:

Signature of Reviewer: ______________________________Date: __________