QUALITY ASSURANCE FOR ABORIGINAL MEDICAL SERVICES

PROGRAM MANAGEMENT

2010 QAAMS PROGRAM - ENROLMENT FORM

1. Full **Name of Service**: ....

2. Our service wishes to participate in the following QAAMS Programs in 2010:

   HbA1c ☐ **Urine ACR** ☐ (please tick)

3. Name of the **Contact Person(s)** from your Service responsible for the QAAMS Program:

   ....

   Their position is: Area Health Professional ☐ Nurse ☐ Doctor ☐

   Other ☐ (specify): ....

   Their **phone** number is: ( ) .... Their **fax** number is: ( ) ....

   Their **email address** is: ....

   Their **mobile phone** number is: ....

   Your Full **Street Address** for Delivery of QAAMS 2010 Materials is: ....

   ....

   .... Post Code:

4. Your Full **Postal Address** for Delivery of QAAMS **Quality Assurance** Monthly Summary Reports and/or

   General Program Information is: ....

   ....

   .... Post Code: ....

5. This question is to be completed **ONLY** by those services that have more than one DCA. Do you wish to be enrolled under:

   Separate kits ☐ Results only ☐ (please tick)

6. Instrument Type **(please tick):** ☐ **DCA 2000** ☐ **DCA Vantage**

7. As CEO/Director of this service I, ... (print name), give my approval **for our service to participate in the QAAMS Program for 2010.**

....	....

(Signature of CEO/Director)	Date

Please complete and fax this sheet to Dr Mark Shephard, QAAMS Program Manager, on ***08 8201 7666.***

QAAMS Program Management
Flinders University Rural Clinical School
Dr Mark Shephard
Phone: 08 8201 7555 Fax: 08 8201 7666
Email: Mark.Shephard@flinders.edu.au