



2012 QAAMS PROGRAM - ENROLMENT FORM

1. Full Name of Service:

2. Our service wishes to participate in the following QAAMS Programs in 2012:

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 2012 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 2012.

..... (Signature of CEO/Director)

..... Date

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