qaams
Quality Assurance for Aboriginal & Torres Strait Islander Medical Services
www.qaams.org.au

QAAMS Program Enrolment Form

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

2. Our service wishes to participate in the following QAAMS Program/s (please tick):

   ☐ HbA1c ☐ Urine ACR

3. Name of the ***contact person***(s) from your service who will be responsible for the QAAMS Program:

   _____

   Their ***position*** is: ☐ Area Health Professional ☐ Practice Manager
   ☐ Nurse ☐ Doctor
   ☐ Other (please specify): _____

4. Their ***contact details*** are:

   Phone Number: _____Fax Number: _____Mobile Number: _____

   Email address: _____

5. Your Full ***Street Address*** for delivery of QAAMS materials is:

   _____

   _____Postcode: _____

6. Your Full ***Postal Address*** for delivery of QAAMS Quality Assurance Monthly Summary Reports and/or general program information is:

   _____

   _____Postcode:_____

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

   _____ _____
   (Signature of CEO/Director) Date

Please complete and fax this sheet to the QAAMS Management Team on 08 8201 7666

QAAMS Program Management
Flinders University International Centre for POCT
T (08) 8201 7555 | F (08) 8201 7666