qaams

Quality Assurance for Aboriginal & Torres Strait Islander Medical Services

www.qaams.org.au

QAAMS Program Enrolment Form

Full Name of Service:	
Our service wishes to participate in the following QAAMS Program/s (please tick):	
☐ HbA1c	☐ Urine ACR
Our service wishes to use the Siemens Atellica DCA device (please tick) ☐	
Name of the ***contact person***(s), and their position, from your Health Service who will be responsible for the QAAMS Program:	
☐ Area Health Professional	☐ Practice Manager
☐ Nurse	☐ Doctor
☐ Other (please specify)	
Their ***contact details*** are:	
Phone Number:	Fax Number:
Mobile Number:	Email address:
Health Service Full ***Street Address*** for delivery of QAAMS materials is:	
Address:	
Suburb:	Postcode:
Health Service Full ***Postal Address*** for delivery of QAAMS Quality Assurance Monthly Summary Reports and/ or general program information is:	
Address:	
Suburb:	Postcode:
As CEO/Director of this service, I, (print name), give my approval ***for our service to participate in the QAAMS Program.***	
Please complete and email this sheet to the QAAMS Management Team on qaams@flinders.edu.au	
QAAMS Program Management Flinders University International Centre for POCT T (08) 8201 7555 | E QAAMS@FLINDERS.EDU.AU	