FACILITY ANNUAL SELF ASSESMENT

Date Submitted: ____

Facility Name: ____

Facility Type: ____ PHP ____ RTC ____ SUDRF

EIN#: ____

The above-named facility has conducted an annual self assessment of its compliance with the TRICARE Standards for the appropriate Facility Type as checked above, in accordance with the TRICARE Participation Agreement, Article 3, Performance Provisions, 3.3 Accreditation and Standards. The facility hereby provides notice of any matter regarding which the facility is not in compliance with such Standards as listed below:

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The signees certify that the information in this form is true.

______________________________ ____________________
Chief Executive Officer Date

______________________________ ____________________
Medical Director Date

______________________________ ____________________
Clinical Director Date

______________________________ ____________________
Director of Nursing Date