

Statement of Deficiencies and Plan of Correction	Health Care Clinic File Number	Initial Licensure _____ Renewal _____ CHOW _____ Provisional _____	Date Survey Completed
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Name of Clinic	Street Address, City, State, ZIP Code
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PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEED BY FULL REGUALTORY IDENTIFYIN INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETE DATE
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U-000	<p>INITIAL COMMENTS</p> <p>There were no discernable deficiencies noted at the time of the initial licensure survey on mm/dd/yyyy.</p>			
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AHCA Form 3020 Medical or Clinic Director's or Owner's Representative Signature	Title	Date
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