Appendix B
On Clinic Floors

QUALITY ASSURANCE COMMITTEE

REQUEST FOR ACTION FORM

Patient's Name: _____, _____, _____
(last) (first) (middle initial)

AXIUM No.: _____

Date: _____

Person requesting action: _____ faculty / student
(print) (circle one)

_____
(signature)

Reason for request:

Q.A.C. exam results:

Decision:

Follow up:

Examiners: _____

_____