DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

REQUEST FOR VALIDATION OF ACCREDITATION SURVEY FOR HOSPITAL

1. NAME AND ADDRESS OF STATE AGENCY	2. NAME AND ADDRESS OF HOSPITAL PROVIDER NUMBER
3. HOSPITAL ACCREDITED BY: ☐ JCAHO ☐ AOA	4. PLEASE REQUEST COMPLETION OF ☐ CMS-2567

5. ☐ PLEASE DO NOT NOTIFY THE HOSPITAL IN ADVANCE OF YOUR SURVEY.

6. ☐ THIS VALIDATION IS BASED ON A SAMPLE SELECTION.
THE DATE OF LAST ACCREDITATION SURVEY WAS _____ . PLEASE CONDUCT A FULL VALIDATION SURVEY WITHIN 60 DAYS.
CONFINE THE SURVEY TO THOSE CONDITIONS OF PARTICIPATION FOR WHICH ACCREDITED HOSPITALS ARE DEEMED TO MEET.

☐ THIS VALIDATION IS BASED ON ALLEGATIONS OF SIGNIFICANT DEFICIENCIES WHICH COULD AFFECT THE HEALTH AND SAFETY OF PATIENTS IN THIS HOSPITAL. PLEASE CONDUCT A SURVEY WITHIN 45 DAYS AFTER THIS REQUEST, FOR THE PURPOSE OF ASCERTAINING WHETHER THE HOSPITAL MEETS THE CONDITIONS CHECKED.

7. AREAS TO BE SURVEYED *(Check all applicable Conditions; enter all applicable Standards)*

CONDITION(S)	STANDARDS
☐ Federal, State and Local Laws(482.11)	
☐ Governing Body (482.12)	
☐ Patient Rights (482.13)	
☐ Quality Assurance (482.21)	
☐ Medical Staff (482.22)	
☐ Nursing Services (482.23)	
☐ Medical Record Services (482.24)	
☐ Pharmaceutical Services (482.25)	
☐ Radiologic Services (482.26)	
☐ Laboratory Services (482.27)	
☐ Fatal Transfusion Reaction	
☐ Food and Dietetic Services (482.28)	
☐ Utilization Review (482.30)	
☐ Physical Environment (482.41)	
☐ LSC	
☐ Infection Control (482.42)	
☐ Discharge Planning (482.43)	
☐ Organ, Tissue, & Eye Procurement (482.45)	
☐ Surgical Services (482.51)	
☐ Anesthesia Services (482.52)	
☐ Nuclear Medicine Services (482.53)	
☐ Outpatient Services (482.54)	
☐ Emergency Services (482.55)	
☐ Rehabilitation Service (482.56)	
☐ Respiratory Care Services (482.57)	

A COPY OF THE ALLEGATION IS ENCLOSED. A COPY OF THE ALLEGATION WAS PREVIOUSLY FORWARDED TO THE ACCREDITING AGENCY. THE NAME OF THE COMPLAINANT SHOULD NOT BE DISCLOSED UNLESS THERE IS SPECIFIC AUTHORIZATION.

8. SIGNATURE OF REGIONAL REPRESENTATIVE	9. REGION	10. DATE

Form CMS-2802 (12/01)

ORIGINAL TO: STATE SURVEY AGENCY

COPIES TO: CMS Accreditation Staff
Accreditation Organization