



SITE ASSESSMENT TOOL

Please complete a form for each ACTIVE office location

(Be sure to make additional copies, one for each location)

Practice Name: _____

Street: _____

City/State/Zip Code: _____

Office Phone#: _____ Office Fax#: _____

Please list the hours the "Provider" is at this location:

M - T - W - TH - F - SAT - SUN -

NOTE: For any NO response, please provide an explanation on a separate sheet of paper.

AMERICAN DISABILITY ACT (view at ada.gov/racheck.pdf)

1. Does this office meet ADA accessibility requirements? YES NO

PHYSICAL ACCESSIBILITY

2. Facility entry is handicapped accessible? YES NO

3. Bathrooms are handicapped accessible? YES NO

4. Exam Tables are handicapped accessible? YES NO

5. Office Hours are posted in office? YES NO

PHYSICAL APPEARANCE

6. Floors, walkways, rooms, entrances and exits are clean and free of clutter? YES NO

7. Bathrooms and hand washing areas have hot water, soap and paper towels/air dryers? YES NO

8. Sufficient lighting (indoors and outdoors)? YES NO

9. Fire extinguishers, smoke detectors and sprinklers are present, accessible and in working order? YES NO

10. Evacuation plan is displayed? YES NO

ADEQUATE SPACE IN WAITING AREA AND EXAM ROOMS

11. Adequate seating in waiting room (3 chairs per physician)? YES NO

12. Exam room equipped with adequate space/privacy? YES NO

ADEQUACY OF MEDICAL/TREATMENT RECORD KEEPING

13. Medical records are filed securely, easily accessible and limited to authorized personnel? YES NO

14. All entries are legible, signed and dated? YES NO

15. HIPAA Privacy Notice is visibly displayed and distributed to all patients? YES NO

I, the undersigned, attest that the information on this form is complete and accurate.

Signature and Title of Authorized Personnel

Date

SCORE: _____