

## Hospital OQR Extraordinary Circumstances Extension or Waiver for Reporting Quality Data\*

<b>Date of Request</b>	
<b>Date of Extraordinary Circumstance</b>	
<b>Hospital ID/CCN</b>	
<b>Hospital Name</b>	
<b>Contact Information for Hospital CEO or Other Hospital-Designated Personnel</b>	
<b>E-Mail Address of Hospital CEO or other Hospital-Designated Personnel</b>	
<b>Telephone Number of Hospital CEO or Other Hospital-Designated Personnel</b>	
<b>Address (no post office boxes, please) of Hospital CEO or Other Hospital-Designated Personnel</b>	
<b>City</b>	
<b>State and ZIP Code</b>	
<b>Name of Additional Designated Personnel</b>	
<b>Designated Personnel E-Mail Address</b>	
<b>Designated Personnel Address (no post office boxes, please)</b>	
<b>City</b>	
<b>State and ZIP Code</b>	
<b>Type of Extraordinary Circumstance</b>	
<b>Hospital's Reason for Requesting an Extension or Waiver</b>	

<b>Evidence of the Impact of the Extraordinary Circumstance, e.g., Photographs, Newspaper and Other Media Articles, etc.</b>	
<b>Submission Quarters Affected</b>	
<b>Validation Quarters Affected</b>	
<b>Estimated Date When Hospital Would Again Be Able to Submit Hospital OQR Data</b>	
<b>Justification for Proposed Date</b>	
<b>Additional Comments</b>	

**\*Please attach additional pages or documents as necessary.**

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***Signature, Chief Executive Officer  
or Other Hospital-Designated Personnel***

***(Print Name)***



**Hospital Outpatient Quality  
Reporting Program**  
Support Contractor



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