

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

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

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

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

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

(Print Name)



This material was prepared by FMQAI, the Support Center for the Hospital Outpatient Quality Reporting program, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). The contents presented do not necessarily reflect CMS policy. FL-10SOW-2013FS4T11-1-522