



CONTRA COSTA HEALTH SERVICES
Emergency Medical Services
PARAMEDIC INTERFACILITY TRANSFER (CCT-P) PROGRAM

Continuous Quality Improvement Plan Approval Form

Name of Ambulance Provider: _____

Person responsible For Clinical Oversight: _____

Address: _____

Phone: _____ e-mail _____

Person who will be providing CQI activities (if different from above):

Address: _____

Phone: _____ e-mail _____

Attach a copy of the Provider's QI Plan.