# Corrective Action Plan

## SLI Compliance Email to: acb@slicompliance.com

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| Company and Contact Information |
| **Company Name** |  |
| **Contact Name** |  |
| **Email** |  |
| **Phone** |  |
| Affected Certified Product Information |
| **Certified Product Name** |  |
| **Certified Product Version(s) Affected** |  |
| **All CHPL Product Number(s)**issued to this SLI certified product |  |
| INSTRUCTIONS: Complete the column on the right for each row (light yellow cells). |
| Description and Assessment |
| **Description** of the identified non-conformity/ies or deficiency/ies |  |
| **Identification** of certified criteria or transparency requirement affected (e.g., 170.315(b)(1) or, for transparency, 170.523(k)(1) ) – List all affected requirements |  |
| **Assessment** of how widespread or isolated the identified non-conformities or deficiencies may be across all the customers and users of the certified product (all versions) |  |
| Corrective Action Plan |
| **Plan for addressing** the identified non-conformities or deficiencies at locations of all potentially affected customers and users |  |
| **Plan for notifications** and confirmations:1. How will you ensure that all affected and potentially affected customers and users are alerted to the identified non-conformities or deficiencies? Include a detailed description of how you will assess the scope and impact of the problem, including identifying all potentially affected customers.
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| 1. How will you promptly ensure that all potentially affected customers are notified of the problem and plan for resolution?
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| 1. How and when will you resolve issues for individual affected customers?
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| 1. How will you ensure that all issues are, in fact, resolved?
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| **Date you will confirm** with SLI that you have completed all elements of the corrective action plan |  |
| **Any additional elements** specified by the ONC or that SLI deems appropriate, consistent with our accreditation. (These are based on the specific findings, and guidance will be provided if this requirement is applicable.) |  |
| Statement of Compliance |
| **I attest that the statements in this document are complete and accurate.** |
| **Name of Authorized Representative** |  |
| **Signature of Authorized Representative** |  |
| **Date (MM/DD/YYYY)** |  |

 **\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*STOP HERE WHEN FIRST SUBMITTING THE CORRECTIVE ACTION PLAN\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

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| INSTRUCTIONS: Upon completion of the Corrective Action Plan, you are required by the ONC to attest to having completed all elements of the Corrective Action Plan. Please re-send your original form with the following section completed. Complete the column on the right for each applicable row (light green cells). |
| Statement of Completion (do NOT fill in this section until the CAP is completed and confirmed) |
| **NOTES** from developer, if needed (including any revisions or amendments to the original plan) |  |
| **I attest that the Corrective Action Plan specified in this document is complete.** |
| **Name of Authorized Representative** |  |
| **Signature of Authorized Representative** |  |
| **Date (MM/DD/YYYY)** |  |