Request for BFHI Assessment – COMMUNITY FACILITY

Name of facility requesting assessment:	_____
Type of Service:	_____
Name of Person Coordinating Assessment:	_____
Position:	_____
Phone:	_____
Email:	_____
Address:	_____ State: _____ Post Code: _____
Postal Address: (PO Box)	_____ State: _____ Post Code: _____
Suggested dates for assessment:	_____ *Be sure to suggest two consecutive days that maximise attendance of executive staff, midwifery staff and mothers i.e. weekdays, antenatal clinic days, postnatal morning tea*
Will the assessment team need to provide evidence of security checks? i.e. Working With Vulnerable People	Yes ☐ No ☐ If yes, provide details: *This may incur additional cost to the facility.*

SIGNED: _____ **DATE:** ____ / ____ / _____

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