



REQUEST FOR QUOTE PRE-ASSESSMENT VISIT AND / OR CERTIFICATION AUDIT

Before we can prepare a proposal for a pre-assessment visit and/or a certification audit of your management systems, we need certain information about your organisation. We therefore kindly request that you complete this form and return it to the Auckland BVQi office Fax 09 520 52229 or email cecilia.niu@nz.bureauveritas.com. We will then develop a quotation tailored to your situation in doing this we may contact you to seek more information.

Please note that your application in no way commits you to using our services and that no application fee will be charged.

Part One – Company Details

Registered Company/Organisation Name:

Company: [] **Partnership:** [] **Sole Trader:** []

Company Address:

Trading Name:

Mailing Address: (For Correspondence)

Email Address:

Telephone No:

Fax No:

Name of Chief Executive:

**Name of person nominated for liaison with BVQi:
& their position in the company:**

Do you require certification for more than one site: Yes: [] **No:** []
If Yes, number of sites: [] (please complete list on next page)

Main Site Address:



Where are the clients' notes kept? Centrally Yes No At the sites listed below Yes No

Are they kept electronically? Fully electronic Yes No Partially electronic Yes No

Can all the patient information be viewed at one site? _____

List additional site addresses to be audited:

Name /Sites (where a physiotherapist works more than 12 hours per week)	Address	Contact Person	Scope of service i.e. Acupuncture Skeletal	Number of FTE Physiotherapist at each site	Active patient numbers at each site*	Other information you feel is important and may help us understand your business.

* Regular clients currently being seen by a Physiotherapist in the practice, please provide the total number of active clients by each site.



Part Two – Services Required

Pre-Assessment /Gap Analysis Visit (Optional)

Please tick if this is required: []

Audit for the NZ Physiotherapy Accreditation Scheme Standards 2003

Please tick if this is required []

Certification Audit Date

Please indicate the approximate time you intend to have your certification audit.

I declare that the above information provided is true and accurate.

Authorised Signatory: _____

Full Name: _____

Position: _____

Date: _____