Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number** 01D2099823	**(X3) Date Survey Completed** 03/14/2018
Name of Provider or Supplier Family Medical Associates West	**Street Address, City, State** 26279 Hwy 195, Double Springs, AL	

For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.

(X4) ID Prefix Tag	**Summary Statement of Deficiencies**
No Tags	No deficiency details available.