Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	19D2125826	03/26/2018
Name of Provider or Supplier	**Street Address, City, State**	
Southern Vascular Associates	5000 Ambassador Caffery Pkwy, Bldg 1, Ste 100, Lafayette, LA	

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.