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| <b>Statement of Deficiencies</b>   | <b>(X1) Provider/Supplier/CLIA Identification Number</b><br><br>37D0473055            | <b>(X3) Date Survey Completed</b><br><br>05/03/2018 |
| <b>Name of Provider or Supplier</b><br><br>Family Medicine Associates  | <b>Street Address, City, State</b><br><br>3100 S Elm Place, Suite A, Broken Arrow, OK |   |
| For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency. |   |   |

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| <b>(X4) ID Prefix Tag</b> | <b>Summary Statement of Deficiencies</b> |
| <b>D0000</b>              |  |