Department of Health & Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0391

Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number** 37D2012262	**(X3) Date Survey Completed** 02/02/2018
Name of Provider or Supplier Ou Medicine, Inc Reproductive Health	**Street Address, City, State** 840 Research Parkway, Suite 200, Oklahoma City, OK	
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**
D0000	