Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	47D0091586	01/08/2018
Name of Provider or Supplier	**Street Address, City, State**	
Cvmc Central Vermont Oncology	195 Hospital Loop, Berlin, VT	

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.