MATERNITY CARE PROGRAM
QUALITY IMPROVEMENT TRACKING LOG

DISTRICT (SITE)_____
PRIMARY CONTRACTOR_____
QUARTER_____**YEAR**_____

REVIEW SOURCE	DATE ID'D	PROVIDER OR RECIPIENT NAME	QUALITY ISSUE	PERSON RESPONSIBLE	DATE TO QA COMMITTEE	QA RECCOMENDATIONS	FOLLOW-UP	QUALITY ISSUE OPEN/CLOSED	DATE CLOSED