PM Form 8.5.3
Medical Care Evaluation (MCE) Quarterly Progress Report

Name of facility: ______________________________

DBHS provider ID: ______________________________

Title of study: ______________________________

MEC study period: ______________________________

Submission date: ______________________________

Synopsis of Quarterly Activities and Progress
Findings:
Monitoring results, graphs, etc. (Please attach copies):
Preliminary conclusions:
Actions taken to date:

Signature of QM staff member ______________________________ **Date** __________