

CALIFORNIA CABG OUTCOMES REPORTING PROGRAM Extension Request Form

PHONE (916) 326-3865
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HCAI-CCORP 418 (Revised 06/17)

Extension Request Form

Hospital Name:

Facility ID:

Date:

Report Period: Begin Date: End Date:

Number of Days of Extension Request:

Extension request submitted by:

Name and Title (Please print)

Phone Number: Fax Number:

Signature:

HCAI USE ONLY

Extension Request (circle one): **Granted** **Denied**

By: Date of CORC System Input: