State of Illinois Department of Human Services
Treatment and Detention Facility

PROCEDURES AND POLICIES ANNUAL REVIEW

Procedure/Policy Title: _____

Department: _____ Date of Review: _____

Revision(s) Required: ☐ Yes ☐ No

If yes, indicate section(s) of proposed revisions, _____, and write proposals below.
If necessary attach additional paper. _____

_____

_____

_____ _____
QA Director Date

☐ I Concur ☐ I Do Not Concur

Comments: _____

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_____ _____
Department Head Date

☐ I Concur ☐ I Do Not Concur

Comments: _____

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_____ _____
Program Director Date