CALIFORNIA CABG OUTCOMES REPORTING PROGRAM
Extension Request Form

OSH-CCORP 418 (Revised 06/09)

Healthcare Information Division
Healthcare Outcomes Center
400 R. Street, Room 250
Sacramento, CA 95811
(916) 326-3861 FAX (916) 445-7534

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:

OSHPD USE ONLY

Extension Request (circle one): Granted Denied

By: Date of CORC System Input :