**Home Visiting Continuous Quality Improvement (CQI) Team Meeting**

|  |  |
| --- | --- |
| Location |  |
| Date |  |

**CONFIDENTIALITY STATEMENT:**

In becoming a participant on one of the Continuous Quality Improvement Teams, I hereby agree to hold all information obtained in the course of this and future meetings in the strictest of confidence.

My signature implies that I respect the privacy of the participants in the DHSS Home Visiting program, the Missouri Department of Health and Senior Services, the DHSS Home Visiting program personnel, community partners, and stakeholders, and will not disclose any information regarding children or families discussed in the meetings.

Signature below constitutes understanding of the above information.

| **NAME and Position (Please Print)\*** | **Agency** | **Email Address** | **Signature** |
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