MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION OF HEALTH STANDARDS AND LICENSURE

APPLICATION FOR TRAUMA VERIFIED HOSPITAL DESIGNATION

In accordance with the requirements of Chapter 190, RSMo, and the applicable regulations, this application is hereby submitted for designation as a trauma center. Please complete all information.	Organization's Trauma Identification Number

CURRENT TRAUMA VERIFICATION ORGANIZATION AND LEVEL

ADULT AND PEDIATRIC (TREATS ADULTS AND CHILDREN)	PEDIATRIC (TREATS CHILDREN ONLY)	ADULT (TREATS ADULTS ONLY)
☐ Level I Trauma Center by the American College of Surgeons	☐ Level I Pediatric Trauma Center by the American College of Surgeons	☐ Level I Trauma Center by the American College of Surgeons
☐ Level II Trauma Center by the American College of Surgeons	☐ Level II Pediatric Trauma Center by the American College of Surgeons	☐ Level II Trauma Center by the American College of Surgeons
☐ Level III Trauma Center by the American College of Surgeons		
☐ Level IV Trauma Center by the American College of Surgeons		

HOSPITAL INFORMATION

Name of Hospital (Name to Appear on Designation Certificate)		Telephone Number
Address (Street and Number)	City	Zip Code

PROFESSIONAL INFORMATION

Chief Executive Officer	Chairman/President of Board of Trustees
Trauma Medical Director (Name, email, and contact phone number)	Trauma Program Manager (Name, email, and contact phone number)

The following should be submitted to the department as indicated:

☐ Proof of trauma verification with the American College of Surgeons with the expiration date of the verification.

CERTIFICATION

We, the undersigned, hereby certify that:

A. Within thirty (30) days of any changes or receipt of a verification, we will submit to the department proof of trauma verification with the American College of Surgeons.

B. Within thirty (30) days, we will submit to the department any changes in the names and/or contact information of our medical director and the program manager of our trauma center.

C. Within thirty (30) days of the date that our hospital is no longer verified by the American College of Surgeons, whether because we voluntarily surrendered our verification or because our verification has been suspended or revoked by the American College of Surgeons or has expired, we will report this change in writing to the department.

D. We will participate in local and regional emergency medical services systems for purposes of providing training, sharing clinical educational resources, and collaborating on improving patient outcomes.

E. We understand that our designation as a trauma center by the department shall continue only if our hospital remains verified as a trauma center by the American College of Surgeons.

Date of application _____

Signed_____
Chairman/President of Board of Trustees,
Owner, or one Partner of Partnership

Signed _____
Hospital Chief Executive Officer

Signed_____
Trauma Medical Director

Signed _____
Director of Emergency Medicine