



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

**APPLICATION FOR ST-ELEVATION MYOCARDIAL INFARCTION (STEMI)  
CERTIFIED HOSPITAL DESIGNATION**

**SECTION A**

In accordance with the requirements of Chapter 190, RSMo, and the applicable regulations, this application is hereby submitted for designation as a STEMI center. Please complete all information.	ORGANIZATION'S STEMI IDENTIFICATION NUMBER
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**CURRENT STEMI CERTIFICATION ORGANIZATION AND LEVEL**

LEVEL I	LEVEL II	LEVEL III
<input type="checkbox"/> Joint Commission, Comprehensive Cardiac Center	<input type="checkbox"/> American Heart Association, Mission Lifeline Percutaneous Coronary Intervention (PCI)/STEMI Receiving Center <input type="checkbox"/> American College of Cardiology, Chest Pain with PCI Center <input type="checkbox"/> American College of Cardiology, Chest Pain with PCI and Resuscitation Center <input type="checkbox"/> Joint Commission, Primary Heart Attack Center <input type="checkbox"/> Joint Commission, Comprehensive Heart Attack Center	<input type="checkbox"/> American Heart Association, Mission Lifeline Non/PCI STEMI Referral Center <input type="checkbox"/> Joint Commission, Chest Pain Center <input type="checkbox"/> Joint Commission, Primary Acute Myocardial Infarction (AMI) Center <input type="checkbox"/> American College of Cardiology, Chest Pain Center <input type="checkbox"/> Joint Commission, Acute Heart Attack Ready Center

**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
STEMI MEDICAL DIRECTOR (NAME, EMAIL, AND CONTACT PHONE NUMBER)	STEMI PROGRAM MANAGER (NAME, EMAIL, AND CONTACT PHONE NUMBER)

**SECTION B**

**The following should be submitted to the department as indicated:**

Proof of STEMI certification with the Joint Commission, American Heart Association or American College of Cardiology with the expiration date of the certification.

**CERTIFICATION**

We, the undersigned, hereby certify that:

- A. Within thirty (30) days of any changes or receipt of a certificate or verification, we will submit to the department proof of STEMI certification with the Joint Commission, American Heart Association or American College of Cardiology.
- 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 the STEMI center.
- C. Within thirty (30) days that our hospital is no longer certified or verified with the Joint Commission, the American Heart Association or the American College of Cardiology, whether because we voluntarily surrendered our certification or verification or because our certification or verification has been suspended or revoked by the Joint Commission, the American Heart Association or American College of Cardiology or 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 STEMI center by the department shall continue only if our hospital remains certified as a STEMI center by the Joint Commission, the American Heart Association or the American College of Cardiology.

DATE OF APPLICATION
SIGNED (CHAIRMAN/PRESIDENT OF BOARD OF TRUSTEES, OWNER, OR ONE PARTNER OF PARTNERSHIP)
SIGNED (HOSPITAL CHIEF EXECUTIVE OFFICER)
SIGNED (STEMI MEDICAL DIRECTOR)
SIGNED (DIRECTOR OF EMERGENCY MEDICINE)