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.

☐ Copy of the final trauma survey results from the American College of Surgeons.

RESOURCE INFORMATION

E.D. Trauma Caseload	Trauma Team Activations	C.T. Scan Capability	M.R.I. Capability
Operating Rooms	ICU/CCU Beds	Burn Beds	Rehab. Beds
Trauma Surgeons	Neurosurgeons	Orthopaedists	E.D. Physicians
Anesthesiologists	C.R.N.A.s	Pediatricians	Pediatric Surgeons

CERTIFICATION

We, the undersigned, hereby certify that:
A. We will annually and within thirty (30) days of any changes submit to the department proof of trauma verification with the American College of Surgeons.
B. We will annually and within thirty (30) days of any changes submit to the department names and contact information of our medical director and the program manager of the trauma center.
C. We will submit to the department a copy of our final trauma verfication survey results from the American College of Surgeons within thirty (30) days of receiving such results.
D. We will participate in the emergency medical services regional system of trauma care in our respective emergency medical services region as defined in 19 CSR 30-40.302.
E. We will participate in local and regional emergency medical services sytems by reviewing and sharing outcome data and providing training and clinical educational resources.
F. We will submit data to meet the data submission requirements outlined in 19 CSR 30-40.430.
G. 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

DRAFT