MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF EMERGENCY MEDICAL SERVICES
APPLICATION FOR TRAUMA CENTER REVIEW AND DESIGNATION

In accordance with the requirements of the Missouri Trauma Center Law (Chapter 190.235, RSMo, Supp. 1990) and the Missouri Trauma Center Regulations (19 CSR 30-45.010-.050) application is hereby made for review and designation as a trauma center.	Designation Level Requested ☐ I ☐ II ☐ III

HOSPITAL INFORMATION

Name Of Hospital (Name To Appear On Designation Certificate)		Telephone Number
Address (Street And Number)	(City)	(Zip)

PROFESSIONAL INFORMATION

Chief Executive Officer	Chairman/President Of Board Of Trustees
Surgeon In Charge Of Trauma Care	Trauma Program Manager
Director Of Emergency Medicine	Director Of Trauma Intensive Care

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 the information provided in this application for trauma center review and designation is true and accurate; and give assurance of the intent and ability of the hospital to comply with regulations promulgated under the Missouri Trauma Center Law (Chapter 190.235 through 190.249, RSMo, Supp 1990).

We further certify that the hospital will comply with all recommendations for improvement contained in the trauma center site review reports prepared by the Missouri Department of Health.

Date of application_____

Signed_____ Signed_____
Chairman/President of Board of Trustees, Owner, or one Partner of Partnership
Hospital Chief Executive Officer

Signed_____ Signed_____
Surgeon In Charge Of Trauma Care
Director of Emergency Medicine

Instructions for Completion of Application For Trauma Center Review and Designation

Section A describes how to complete the attached application form for trauma center review and designation. Section B is a checklist of additional documentation that must be submitted with the application form.

Section A

Designation Level Requested

Indicate whether the hospital is applying for designation as a level I, II, or III trauma center.

Hospital Information

Name of Hospital

Type the name of the hospital as it should appear on the designation certificate.

Telephone Number

Type the telephone number including area code for the administrative offices of the hospital.

Address

Type the street address of the hospital, including city and zip.

Professional Information

Chief Executive Officer

Type the name of the administrative director of the hospital applying for review, not the corporate CEO.

Chairman/President of Board of Trustees

Type the name of the chief officer of the hospital board of directors.

Surgeon in Charge of Trauma Care

Type the name of the Trauma Medical Director, including MD or DO.

Trauma Program Manager

Type the name of the Trauma Program Manager or nurse who fulfills those duties.

Director of Emergency Medicine

Type the name of the physician director of the emergency department, including MD or DO.

Director of Trauma Intensive Care

Type the name of the physician director of the intensive care unit to which trauma patients are *primarily* admitted at the hospital, including MD or DO.

Resource Information

E.D. Trauma Caseload

Indicate the *approximate* number of trauma-related cases seen in the hospital emergency department for the twelve months immediately preceding the month of application. Include all injuries for the estimate.

Trauma Team Activations

Indicate the number of times the full trauma team was activated at the hospital during the twelve months immediately preceding the month of application.

C.T. Scan Capability

If the hospital has an in-house C.T. Scanner that is staffed by in-house personnel 24 hours per day, everyday, indicate FULL as the level of capability.

If the hospital has an off-campus C.T. Scanner, or one that is not staffed by in-house personnel 24 hours per day, everyday, indicate PARTIAL as the level of capability.

If the hospital has no C.T. Scanner, indicate NONE as the capability.

M.R.I. Capability

If the hospital has an in-house M.R.I. that is staffed by in-house personnel 24 hours per day, everyday, indicate FULL as the level of capability.

If the hospital has an off-campus M.R.I., or one that is not staffed by in-house personnel 24 hours per day, everyday, indicate PARTIAL as the level of capability.

If the hospital has no M.R.I., indicate NONE as the capability.

Operating Rooms

Indicate the total number of operating rooms that are used for *trauma* patients at the hospital.

ICU/CCU Beds

Indicate the total number of intensive care beds available for *trauma* patients at the hospital.

Burn Beds

Indicate the total number of beds available for burn patients at the hospital.

Rehab Beds

Indicate the total number of rehabilitation beds available for *trauma* patients at the hospital.

Trauma Surgeons

Indicate the total number of general surgeons that take *trauma* call at the hospital.

Neurosurgeons

Indicate the total number of neurosurgeons that take *trauma* call at the hospital.

Orthopaedists

Indicate the total number of orthopaedic surgeons that take *trauma* call at the hospital.

E.D. Physicians

Indicate the total number of emergency physicians participating in *trauma* care at the hospital.

Anesthesiologists

Indicate the total number of anesthesiologists that take *trauma* call at the hospital.

C.R.N.A.s

Indicate the total number of Certified Registered Nurse Anesthetists that take *trauma* call at the hospital.

Pediatricians

Indicate the total number of pediatricians that take *trauma* call at the hospital.

Pediatric Surgeons

Indicate the total number of pediatric surgeons that take *trauma* call at the hospital.

Certification

Date of Application

Indicate the month, day and year the application is submitted to the Department of Health.

Section B

Please attach the following documentation to the application form:

☐ Hospital organizational chart depicting the relationship of the trauma service to other services and defining the organizational structure of the trauma service.

☐ Job descriptions and C.V. for the Trauma Medical Director and Trauma Program Manager.

☐ A narrative description of the catchement area for the trauma center.

☐ Board resolution supporting the trauma center.

☐ A narrative description of the prehospital system including the hospital's participation in medical control, quality assurance, and education.

☐ Hospital diversion policy.

☐ List of all surgeons and emergency physicians indicating trauma-related CME for each over the last three years.

☐ Copy of the emergency department trauma flow sheet.

☐ Trauma team activation protocol.

☐ Copies of all transfer agreements.

☐ Narrative description of the trauma quality improvement processes utilized by the hospital. (Do not send copies of q.i. minutes or documents-these should be available at the time of review.)

☐ A narrative description of the administrative commitment for the trauma center, including how trauma center designation relates to the overall mission of the hospital.

☐ Examples of trauma-related educational, outreach, and research projects undertaken by the hospital.

☐ Data illustrating:

1. The number of trauma deaths at the hospital (E.D. and inpatient) for the past year.
2. Number of trauma cases transferred to and from the hospital for the past year.
3. Ratio of blunt/penetrating trauma at the institution.
4. Number of patients seen at the hospital with an ISS of 9-15, 16-25, and greater than 25.