Bureau Of Emergency Medical Services and Trauma System
150 N. 18th Avenue, Suite 540, Phoenix, Arizona 85007-3248 602-364-3150

APPLICATION FOR PROVISIONAL TRAUMA CENTER DESIGNATION
A.R.S. Title 36, Chapter 21.1 and A.A.C. Title 9, Chapter 25

☐ **INITIAL APPLICATION** ☐ **180-DAY EXTENSION**

I. HEALTH CARE INSTITUTION INFORMATION

Name of Health Care Institution:			
Address:			
City:	County:	State:	Zip Code:
Main Telephone Number:		Health Care Institution's AZ License Number (if applicable):	

I.A. U.S. GOVERNMENT AGENCY/SOVEREIGN TRIBAL NATION INFORMATION (if applicable)

☐ Administrative Unit of the U.S. Government (*specify*):			
☐ Administrative Unit of a Sovereign Tribal Nation (*specify*):			
Address:			
City:	County:	State:	Zip Code:
Main Telephone Number:			

II. OWNER INFORMATION (As defined in R9-25-1301)

Owner's Name:		
Address:		
City:	State:	Zip Code:
Telephone Number:	Fax Number (if available):	E-mail Address (if available):

III. DESIGNATION INFORMATION

Designation Level for which applying	Level I ☐	Level II ☐	Level III ☐

IV. TRAUMA MEDICAL DIRECTOR (Required if applying for designation as a Level I, II, or III trauma center)

Name:	Telephone Number:
E-mail Address (if available):	Fax Number (if available):

V. CHIEF ADMINISTRATIVE OFFICER FOR HEALTH CARE INSTITUTION

Name:	Telephone Number:
E-mail Address (if available):	Fax Number (if available):

VI. STATUTORY AGENT (or individual designated to accept service of process and subpoenas)

Name:	Title:
Address:	Telephone Number:

VII. ATTACHMENTS (Attach the following, as applicable)

INITIAL APPLICATION	
☐	A copy of the current regular health care institution license issued by the Department, if applicable
180-DAY EXTENSION	
☐	Documentation issued by the American College of Surgeons Committee on Trauma (ACS) establishing that the Owner has applied for verification.
☐	Documentation issued by the American College of Surgeons Committee on Trauma (ACS) showing the Owner's progress in obtaining an ACS site visit for the trauma center

VIII. ATTESTATION

According to A.A.C. R9-25-1304, the application must be signed as follows:

(1) If the Owner is an individual, by the individual;
(2) If the Owner is a corporation, by an officer of the corporation;
(3) If the Owner is a partnership, by one of the partners;
(4) If the Owner is a limited liability company, by a manager or, if the limited liability company does not have a manager, a member of the limited liability company;
(5) If the Owner is an association or cooperative, by a member of the governing board of the association or cooperative;
(6) If the Owner is a joint venture, by one of the individuals signing the joint venture agreement;
(7) If the Owner is a governmental agency, by the individual in the senior leadership position with the agency or an individual designated in writing by that individual; and
(8) If the Owner is a business organization type other than those described in (2) through (6) above, by an individual who is a member of the business organization.

According to A.A.C. R9-25-1305, the owner shall attest to the resources and capabilities necessary to meet the state standards for the Level of designation sought and will meet the state standards for the Level of designation sought during the term of the provisional designation; and
During the term of the provisional designation, the owner will:

-Ensure that the trauma center meets the state standards;
-Apply for verification for the trauma center; and
-Provide to the Department, within 30 days after applying for verification, documentation issued by ACS establishing that the owner has applied for verification.

On behalf of the Owner, I attest that the Owner knows all applicable requirements in A.R.S. Title 36, Chapter 21.1 and A.A.C. Title 9, Chapter 25, Article 13, and that the information provided in this application, including the information in any documents attached to this application form, is accurate and complete.

______________________________ Signature   ______________ Date

______________________________ Name (Printed)   ______________________________ Title

See Page 3 for Instruction on Completing this Application

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR PROVISIONAL TRAUMA CENTER DESIGNATION
(Please type or print in black ink in completing this application)

SELECT THE BOX AT THE TOP OF THE APPLICATION TO INDICATE IF APPLYING FOR AN INITIAL DESIGNATION OR A 180-DAY EXTENSION
SECTION I. HEALTH CARE INSTITUTION INFORMATION
Name of Health Care Institution: Please enter the complete name of your health care institution. If applicable, enter the name as it appears on your current license. The name entered on this line will be the name that appears on your trauma center designation certificate. Address information: Please enter the street address where the health care institution is located. Main Telephone Number: Please enter the telephone number that the general public uses in contacting your health care institution. Health Care Institution AZ License Number: If applicable, please enter the number of your current license.
SECTION I.A. U.S. GOVERNMENT AGENCY/SOVEREIGN TRIBAL NATION INFORMATION
This section only applies if your health care institution is an administrative agent of the U.S. government or is a sovereign tribal nation operating the health care institution as a hospital under federal or tribal law. If this section applies, select the appropriate option. Address information: Please enter the street address where the owner is located. Main Telephone Number: Please enter the telephone that the general public uses in contacting your facility.
SECTION II. OWNER INFORMATION.
Owner's Name: Please enter a response that corresponds with the applicable option for the definition of "Owner" in A.A.C. R9-25-1301(25). Address information: Please enter the street address where the owner is located. Telephone Number/Fax Number/Email Address: Please enter the information for each contact medium that will allow the Department to directly contact the owner.
SECTION III. DESIGNATION INFORMATION.
Designation Level for Which Applying: Please be sure to review the trauma center designation rules carefully when selecting the Level of trauma center designation for which you are applying. You can download a copy of the rules at the following Department website: http://www.azdhs.gov/bems/trauma.htm
SECTION IV. TRAUMA MEDICAL DIRECTOR
Completion of this section is only required for applicants seeking Level I, II, or III trauma center designation.
SECTION V. CHIEF ADMINISTRATIVE OFFICER FOR HEALTH CARE INSTITUTION
Please enter a response that corresponds with the definition of "Chief administrative officer" (CAO) in A.A.C. R9-25-1301(6).
Address information: Please enter the street address where the CAO is located. Telephone Number/Fax Number/Email Address: Please enter the information for each contact medium that will allow the Department to directly contact the CAO.
SECTION VI. STATUTORY AGENT
Please enter the name, title, address, and telephone number of the individual who is designated to accept service of process and subpoenas for your health care institution.
SECTION VII. ATTACHMENTS
Initial Application: This section does not apply if your health care institution is an administrative agent of the U.S. government or is a sovereign tribal nation operating the health care institution as a hospital under federal or tribal law (see Section I.A. of this application).
180-Day Extension: Documentation required for a 180-day extension of a current provisional designation can include ACS notice of verification application receipt; and ACS notice of a site visit date, or other details demonstrating a good faith effort in obtaining a site visit.
SECTION VIII. ATTESTATION
For purposes of this application, A.A.C. R9-25-1304(A)(l)(1) includes an individual in the senior leadership position, or authorized designee, of a sovereign tribal nation operating the health care institution as a hospital under federal or tribal law (see Section I.A. of this application).

Please submit this application with all applicable documents and information as required in rule. If you do not have Internet access, please contact the Bureau of Emergency Medical Services at the telephone number listed below and a copy of the rules will be sent to you.

This application is not considered completed until all required documents and information have been submitted to the Department. If any corrections are made using correction fluid or correction tape, this application will be returned. If an error is made while filling out this application, put a single line through the error with your initials. Please remit the completed application to:

Arizona Department of Health Services
Bureau of Emergency Medical Services and Trauma System
150 N. 18th. Avenue, Suite 540,
Phoenix, Arizona 85007
(602) 364-3158 or 1-800-200-8523