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|  | | | ***Bureau Of Emergency Medical Services & Trauma System***  150 N. 18th Avenue, Suite 540, Phoenix, Arizona 85007-3248; 602-364-3150  **APPLICATION FOR TRAUMA CENTER DESIGNATION BASED ON VERIFICATION BY A NATIONAL VERIFICATION ORGANIZATION**  A.R.S. Title 36, Chapter 21.1 and A.A.C. Title 9, Chapter 25 |
| **R9-25-1302** | | **DESIGNATION ELIGIBILITY** | |
| Health Care Institution (HCI) is eligible for designation as a Level I trauma center, Level I Pediatric trauma center, Level II trauma center, Level II pediatric center, Level III trauma center based on verification issued by a National Verification Organization (NVO) if the HCI is either:   * Licensed by the Department under 9A.A.C 10 to operate as a hospital; or * Operating under federal or tribal law as an administrative unit of the U.S. government or a sovereign tribal nation, and meets one of the requirements listed in section 1-1 of this application:   A HCI is eligible for Level IV trauma center designation based on verification issued by a NVO if the HCI meets one of the requirements listed in 1-1 of this application and is either:  Licensed by the Department under 9 A.A.C. 10 to operate as a hospital; or   * An outpatient treatment center authorized to provide emergency room services, as defined in A.A.C. R9-10-1001, according to A.A.C. R9-10-1019; or * Operating as a hospital or an outpatient treatment center providing emergency services under federal or tribal law as an administrative unit of the U.S. government or sovereign tribal nation, and meets one of the requirements listed in section R9-25-1302(B). | | | |
| **1-1** | **ELIGIBILITY FOR DESIGNATION BASED ON (check appropriate box’s below) R9-25-1302** | | |

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| Holds verification at the level sought, issued within six months before the date of designation from a National Verification Organization (NVO).  Has documentation issued by the NVO within six months before the date of designation that the HCI meets state standards specified in R9-25-1308 and Table 13.1 for the designation level sought.  **\*Please note that if your HCI chooses the verification pathway to designation you are waiving the opportunity to be assessed by the Department.** |

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| 1-2 | **DESIGNATION RENEWAL** |
| An owner applying to renew designation for a HCI shall submit an application to the Department at least 60 calendar days and no more than 90 calendar days before the expiration of the current designation R9-25-1303. If an owner submits an application for renewal of designation before the expiration date of the current designation, the designation of the HCI remains in effect until the Department has determined whether or not issue a renewal of the designation, or the application is withdrawn by the applicant. | |

**INITIAL DESIGNATION**  **RENEWAL DESIGNATION**

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|  | **HEALTH CARE INSTITUTION INFORMATION** | | | | | | | | | | | | |
| Name of HCI (HCI): | | | | | | | | | | | | | |
| Address: | | | | | | | | | | | | | |
| City: | | | | | | | | State: | | | | Zip Code: | |
| Main Telephone Number: | | | | | | | | HCI’s AZ License Number (if applicable): | | | | | |
| **2-2** | U.S. GOVERNMENT AGENCY/SOVEREIGN TRIBAL NATION INFORMATION (if applicable) | | | | | | | | | | | | |
| Administrative Unit of the U.S. Government (*specify*): | | | | | | | | | | | **FOR OFFICIAL USE ONLY:** | | |
| Administrative Unit of a Sovereign Tribal Nation (*specify*): | | | | | | | | | | |
| Address: | | | | | | | | | | |
| City: | | County: | State: | | Zip Code: | | | | | |
| Main Telephone Number: | | | | | | | | | | |
| **Please attach documentation demonstrating the HCI is operating as a hospital or an outpatient treatment center providing emergency services under federal or tribal law as an administrative unit of the U.S government or a sovereign tribal nation.** | | | | | | | | | | | | | |
| **2-3** | **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): | |
| **2-4** | **OWNER’S STATUTORY AGENT INFORMATION *(or individual designated to accept services of process and subpoenas)*** | | | | | | | | | | | | |
| Agents Name: | | | | | | | | | Agents Title: | | | | |
| Address: | | | | | | | | | | | | | |
| City: | | | | | | | | State: | | | | Zip Code: | |
| Telephone Number: | | | | | | Fax Number (if available): | | | | | | E-mail Address: | |
| **2-5** | **CHIEF ADMINISTRATIVE OFFICER *(as defined in A.A.C. R9-10-101 for HCI)*** | | | | | | | | | | | | |
| Officer’s Name: | | | | | | | | | Officer’s Title: | | | | |
| Address: | | | | | | | | | | | | | |
| City: | | | | | | | | | | State: | | Zip Code: | |
| Telephone Number: | | | | | | Fax Number (if available): | | | | | | E-mail Address: | |
| **2-6** | **TRAUMA PROGRAM MANAGER *(as defined in R9-25-1303(A)(i))*** | | | | | | | | | | | | |
| Name of Trauma Program Manager ► | | | | | | | | | | | | | |
| E-Mail address: ► | | | | | | | Phone #: ► | | | | | | Fax # *(if available):* ► |
| **Please attach Trauma Program managers job description documentation** | | | | | | | | | | | | | |
| **2-7** | **TRAUMA PROGRAM MEDICAL DIRECTOR *(as defined in R9-25-1303(A)(n))*** | | | | | | | | | | | | |
| Name of Trauma Medical Director,► | | | | | | | | | | | | | |
| E-Mail address: ► | | | | | | | Phone #: ► | | | | | | Fax # *(if available):* ► |
| **Please attach documentation of Trauma Medical Director’s credentials as required in A.A.A.R9-25-1308(F)(4)&(10) (surgery board certification or eligibility and current trauma critical care course certification)** | | | | | | | | | | | | | |
| **2-8** | **DESIGNATION INFORMATION *(as defined in R9-25-1303(A)(d)(e)(f)(g)*** | | | | | | | | | | | | |
| Designation Level for which applying:  Level I  Level I Pediatric Level II Level II Pediatric  Level III  Level IV | | | | | | | | | | | | | |
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| \*Stop now if you are applying for designation as a Level III or Level IV center based solely on a State assessment of the applicable standards specified in R9-25-1308 and Table 13.1. **OR** if you are a Level I, Level I Pediatric, Level II, Level II pediatric center that is seeking designation at a different level than your verification please complete the application located here: <https://www.azdhs.gov/documents/preparedness/emergency-medical-services-trauma-system/trauma/application-for-trauma-center-designation.docx> | | | | | | | | | | | | | |

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| **3-1** | **VERIFICATION INFORMATION *(as defined in R9-25-1303(A)(f)*** | | | | |
| If applying for designation of a Level I, Level I Pediatric, Level II, Level II Pediatric, Level III, or Level IV trauma center has the HCI applied to a NVO? Yes  No | | | | | |
| Name of NVO: | | | | | |
| Name of NVO representative: | | | | | |
| Telephone Number: | | | | E-mail Address (if available): | |
| The date the NVO is scheduled to assessed the HCI: | | | | | |
| The level of NVO verification held?  Level I  Level I Pediatric Level II Level II Pediatric  Level III Level IV | | | | | |
| Effective date of NVO: | | | Expiration Date of NVO: | | |
| For HCI’s applying for initial designation, the date the HCI will begin providing trauma services: | | | | | |
| **TRAUMA REGISTRY AND DATA COLLECTION** | | | | | |
| **4-1** | **TRAUMA REGISTRY INITIAL DESIGNATION *(as defined in R9-25-1303(A)(1)(l))*** | | | | |
| If applying for designation as a Level IV trauma center which of the following data sets will the HCI be submitting:  Please check one of the following  Full data set  Reduced data set *(level IV only)* | | | | | |
| If not already submitting trauma registry data to the Department, the time period for which the HCI plans to begin submitting trauma registry information:  January 1st,      ,  April 1st,      ,  July 1st,      ,  October 1st, | | | | | |
| **4-2** | **CENTRALIZED REGISTRY SUBMISSION *(as defined in R9-25-1303(A)(1)(j))*** | | | | |
| Will the HCI’s trauma registry be part of a centralized trauma registry? Yes  No | | | | | |
| If yes, Please provide a description of the training provided to the trauma program manager to enable the trauma program to comply with R9-25-1308(D) (2) in the space provided below.  Copy and paste your response here or provide it in a separate attachment: ► | | | | | |
| ***R9-25-1308(D)(2): Each trauma center contributing information to the centralized trauma registry is able to:***   1. ***Access, edit, and update the information contributed by the trauma center to the centralized trauma registry; and*** 2. ***Use the information contributed by the trauma center to the centralized trauma registry when complying with performance improvement process (PIP) requirements.*** | | | | | |
| **4-3** | **REGISTRY PERSONNEL *(as defined in R9-25-1308(B)(2))*** | | | | |
| Registrar’s Name: | | | | | |
| Telephone Number: | | Fax Number *(if available)*: | | | E-mail address: |
| Registrar’s Name: | | | | | |
| Telephone Number: | | Fax Number *(if available)*: | | | E-mail address: |
| Registrar’s Name: | | | | | |
| Telephone Number: | | Fax Number *(if available)*: | | | E-mail address: |
| Registrar’s Name: | | | | | |
| Telephone Number: | | Fax Number *(if available)*: | | | E-mail address: |

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| **ATTESTATION AND SIGNATURES** | |
| **5-1** | **LICENSING DECISION *(as defined in §41-1030)*** |
| Pursuant to Arizona Revised Statute §41-1030:   * An agency shall not base a licensing decision in whole or in part on a licensing requirement or condition that is not specifically authorized by statute, rule or state tribal gaming compact.  A general grant of authority in statute does not constitute a basis for imposing a licensing requirement or condition unless a rule is made pursuant to that general grant of authority that specifically authorizes the requirement or condition. * This section may be enforced in a private civil action and relief may be awarded against the state.  The court may award reasonable attorney fees, damages and all fees associated with the license application to a party that prevails in an action against the state for a violation of this section. * A state employee may not intentionally or knowingly violate this section.  A violation of this section is cause for disciplinary action or dismissal pursuant to the Agency's adopted personnel policy. * This section does not abrogate the immunity provided by section 12‑820.01 or 12‑820.02. | |
| **5-2** | **OWNER ATTESTATION** |
| According to A.A.C. R9-25-102 Individual to Act for a person regulated under this chapter (Authorized by A.R.S § 36-2202)  When a person regulated under this chapter is required by this chapter to provide information on or sign an application form or other document, the following individual shall satisfy the requirement on behalf of the person regulated under this Chapter:  (1) If the person regulated under this chapter is an individual, the individual; or  (2) If the person regulated under this chapter is a business organization, political subdivision, government agency, or  tribal government, the individual who the business organization, political subdivision, government agency, or tribal  government has designated to act on behalf of the business organization, political subdivision, government agency,  or tribal government and who;  a. Is a U.S. citizen or legal resident, and  b. Has an Arizona address. | |
| **I attest that the owner of the HCI will prohibit the trauma medical director from serving as trauma medical director for another HCI.**  **I attest that the owner of the HCI will prohibit a physician on-call for general surgery, neurosurgery, or**  **orthopedic surgery to be on-call or on back-up call list at another HCI.**  **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 the documents attached to this application for is accurate and complete.**  **I attest the owner will comply with all applicable requirements in A.R.S. Title 36, Chapter 21.1 and this Article**  **I understand that by choosing the verification pathway to trauma designation I am waiving the opportunity to have an assessment by the Department.**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature, Chief Administrative Officer Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name (Printed) | |