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| **Pediatric Ready Facility Recognition Application** | | | | | |
| Date of Application  Select date | Type of Application  Select type | | | Designation Level Requested  Pediatric: Select level | |
| **Mission**  South Carolina will recognize emergency centers as pediatric ready with identified criteria.  **Vision**  Ensure that every child in South Carolina gets the best care, in every emergency department, every time. | | | | | |
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| **HOSPITAL INFORMATION** | | | | | |
| Name of Hospital (Name to Appear on Designation Certificate)   Type Name of Hospital Here | | | | | |
| Address (Street Number and Name)   Type Address Here | | (City)   Type City Here | | | (Zip)  Type Zip Here |
| Telephone Number   Type Telephone Number Here | | Tax ID   Type Tax ID Here | | | |
| **RESOURCE INFORMATION** | | | | | |
| **Number of total Pediatric Ready ED Rooms**  Enter Number Here  **C.T. Scan Capability (Y/N)**  Select Yes or No | | **Pediatric Admission Capacity:**  Enter Number Here  **Pediatric General Beds:**  Enter Number Here  **Pediatric ICU Beds:**  Enter Number Here | | | |
| **PLEASE CHOOSE *ONE* OF THE FOLLOWING:** | | | | | |
| SCDPH will touch base with your facility’s primary contact to schedule the survey.Please indicate below a timeframe in which you would like to be surveyed. Although SCDPH will try to accommodate your request, there is no guarantee that you will be visited within the chosen timeframe.  Within the next 3 months  6 months  9 months  12 months  Add: Documentation for PI must be within the last 6 months. | | | | | |
| **Internal Use Only:** | | | | | |
| Site visit: | | | Team Members: | | |
| Initial: Click here to enter a date. | | |  | | |
| Follow up: Click here to enter a date. | | |  | | |
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| **NOTES:**  **SIGNATURES:** The following signatures certify the review and endorsement of this application, if applicable. | | | | | |

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| **Department Directors** | **Directors Contact Information** | |
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| Physician Champion for Pediatric Emergency Care  Type Name and Title Here  Type Phone Number Here  Type Email Address Here | Signature (below) | Date  Select date |
| Nurse Coordinator for Pediatric Emergency Care  Type Name Here  Type Phone Number Here  Type Email Address Here | Signature (below) | Date  Select date |
| Chief of Staff  Type Name Here  Type Phone Number Here  Type Email Address Here | Signature (below) | Date  Select date |
| Director of Emergency Medicine  Type Name and Title Here  Type Phone Number Here  Type Email Address Here | Signature (below) | Date  Select date |
| Emergency Department Director  Type Name and Title Here  Type Phone Number Here  Type Email Address Here | Signature (below) | Date  Select date |
| Trauma Program Manager, If applicable  Type Name and Title Here  Type Phone Number Here  Type Email Address Here | Signature (below) | Date  Select date |
| Pediatrics/Internal Medicine, If applicable  Type Name and Title Here  Type Phone Number Here  Type Email Address Here | Signature (below) | Date  Select date |
| Chief of Surgery  Type Name and Title Here  Type Phone Number Here  Type Email Address Here | Signature (below) | Date  Select date |
| Chief of Medicine  Type Name and Title Here  Type Phone Number Here  Type Email Address Here | Signature (below) | Date  Select date |
| I attest to the validity of the content of this application and confirm our facility's readiness to proceed with the recognition process.  Senior Leadership:  Type Name Here  Type Phone Number Here Date:  Type Email Address Here \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Select date  Signature | | |