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| **Pediatric Ready Facility Recognition Application** |
| Date of ApplicationSelect date | Type of ApplicationSelect type | Designation Level RequestedPediatric: 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 monthsAdd: 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 CareType Name and Title HereType Phone Number Here Type Email Address Here  | Signature (below) | DateSelect date |
| Nurse Coordinator for Pediatric Emergency CareType Name HereType Phone Number Here Type Email Address Here | Signature (below) | DateSelect date |
| Chief of StaffType Name HereType Phone Number Here Type Email Address Here | Signature (below) | DateSelect date |
| Director of Emergency MedicineType Name and Title HereType Phone Number Here Type Email Address Here | Signature (below) | DateSelect date |
| Emergency Department DirectorType Name and Title HereType Phone Number Here Type Email Address Here | Signature (below) | DateSelect date |
| Trauma Program Manager, If applicableType Name and Title HereType Phone Number Here Type Email Address Here | Signature (below) | DateSelect date |
| Pediatrics/Internal Medicine, If applicableType Name and Title HereType Phone Number Here Type Email Address Here | Signature (below) | DateSelect date |
| Chief of Surgery Type Name and Title HereType Phone Number Here Type Email Address Here | Signature (below) | DateSelect date |
| Chief of Medicine Type Name and Title HereType Phone Number Here Type Email Address Here | Signature (below) | DateSelect 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 HereType Phone Number Here Date: Type Email Address Here \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Select dateSignature |