ALABAMA DEPARTMENT of PUBLIC HEALTH
OFFICE of EMS

MAIL TO: OFFICE OF EMS, P.O. BOX 303017, MONTGOMERY, AL 36130-3017

APPLICATION For TRAUMA CENTER DESIGNATION

Section A: LEVEL OF CLASSIFICATION/DESIGNATION

Application Type: ☐ New ☐ Recertification

Classification/Designation Level (Check):	**None**	**Level I**	**Level II**	**Level III**
Current Level:	☐	☐	☐	☐
Applying for:		☐	☐	☐

Section B: FACILITY IDENTIFYING INFORMATION

Name of Hospital to appear on Certificate: _____

Facility Name: _____

Mailing Address (include street address): _____

City: _____ State: _____ Zip: _____ County: _____

Telephone (xxx-xxx-xxxx): _____ Fax (xxx-xxx-xxxx): _____

Trauma Medical Director (Name, Title): _____

E-mail: _____

Telephone (xxx-xxx-xxxx): _____ Fax (xxx-xxx-xxxx): _____

Trauma Program Coordinator/Manager (Name, Title): _____

E-mail: _____

Telephone (xxx-xxx-xxxx): _____ Fax (xxx-xxx-xxxx): _____

Physician Director of Emergency Medicine (Name, Title): _____

E-mail: _____

Telephone (xxx-xxx-xxxx): _____ Fax (xxx-xxx-xxxx): _____

Chief of Surgery (Name, Title): _____

E-mail: _____

Telephone (xxx-xxx-xxxx): _____ Fax (xxx-xxx-xxxx): _____

Contact Person (Name, Title): _____

E-mail: _____

Telephone (xxx-xxx-xxxx): _____ Fax (xxx-xxx-xxxx): _____

Is your hospital/facility is licensed by ADPH Health Provider Standards? If yes, provide license #: _____

Section C: REGIONAL ADVISORY COUNCIL (RAC) NAME:

North ☐ **East** ☐ **BREMSS** ☐ **West** ☐ **Southeast** ☐ **Gulf** ☐

Section D: ACKNOWLEDGEMENT & SIGNATURE(S)

Signature of CEO:	PRINT NAME:	Date Signed:
Signature of Chief of Staff:	PRINT NAME:	Date Signed:
Signature of Chief of Surgery or Trauma Surgical Staff:	PRINT NAME:	Date Signed:

The hospital listed above agrees to abide by the Statewide Acute Health Systems Trauma Hospital Classification/Designation Criteria.

***An application must be submitted for each facility entering the Alabama Statewide Trauma System**

Application for Trauma Center Designation

(Instructions for completing this application)

In accordance with Alabama Trauma System Act § 22-11D-1, et seq. (Code of Alabama 1975) all hospitals in Alabama that wish to participate in the trauma system must determine their classification / designation.
Even though all hospitals are encouraged to apply for state classification / designation as a trauma center, participation remains voluntary.

Complete all sections of the application that apply; do not leave any blank spaces, use N/A as indicated. Blank spaces on the application may be interpreted as an incomplete application. The application may be completed as an electronic form (excluding signatures) or printed and completed by hand (must be legible).

The fillable PDF document requires Adobe Acrobat Pro. If completing the application online follow the steps below:

- Use the 'Tab' key to move through the form
- When you have completed this document, save your work ('File Save') on your computer
- Print the form and obtain needed signatures

If Adobe Acrobat Pro is not available to complete the fillable PDF, print the blank application.

Only the completed and signed application will be accepted. It may be mailed or E-mailed to the addresses listed at the bottom of this page. If emailing a signed copy, afterwards, mail the original to the address at the bottom of the page.

Section A: LEVEL OF CLASSIFICATION/DESIGNATION

Indicate if the application is a new application or re-certification.
List the Hospital as it is to appear on the Certificate;
Choose the hospital's current level, if applicable, and the level being applied for: Level I, Level II, or Level III

Section B: FACILITY INFORMATION

Type the name of the hospital.
Include mailing address.
Include the area code with the telephone number.
Include the city, zip code, and county.
Provide contact information as requested, as applicable, to include the trauma program coordinator/ manager or the name of person who fulfills those duties and the name, email address and telephone number of the person to contact for questions about the application and the assessment if this person is not the trauma program coordinator/manager.

Section C: NAME OF REGIONAL ADVISORY COUNCIL (RAC)

Select the RAC with which the hospital has membership (RACs include): North, BREMSS, East, West, Southeast, and Gulf.

Section D: ACKNOWLEDGMENT AND SIGNATURE(S)

The application must be signed and the dated as indicated before submitting.

NOTE: Questions regarding the classification/designation process and the stroke system are anticipated. There are resources available to assist your facility. In addition to the State Trauma System contacts listed below, Alabama has six Regional Advisory Councils which meet on a regular basis. Attending the RAC meetings is the best way to remain current about the Alabama Statewide Stroke System. The State Trauma and Health Systems Advisory Council (STHSAC) meets on a regular basis. To find out more information on RACs and STHSAC please contact the Acute Health System Manager as listed below or go to the Alabama Department of Public Health Web page, Office of Emergency Medical Services Web page at http://www.alabamapublichealth.gov/ems/health-systems.html

Mail the completed Trauma **A**pplication to:	For questions contact:
Attn: **Alice Floyd, BSN, RN, EMT-P** Acute Health Systems Manager Alabama Department of Public Health Office of Emergency Medical Services P. O. Box 303017 Montgomery, AL 36130-3017	Alice B. Floyd, BSN, R**, EMT-P** Acute Health Systems Manager Alabama Department of Public Health Office of Emergency Medical Services Email: Alice.Floyd@adph.state.al.us Direct: 334-290-6225