Florida Department of Health
Division of Emergency Preparedness and Community Support
Bureau of Emergency Medical Oversight
Trauma Section

Level I Trauma Center

Application Manual

January 2010

Please Submit Application to:

Leah Colston
Bureau Chief
Division of Emergency Preparedness and Community Support
Bureau of Emergency Medical Oversight
Trauma Section
4042 Bald Cypress Way, 2 Floor
Tallahassee, Florida 32399

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY PREPAREDNESS AND COMMUNITY SUPPORT
BUREAU OF EMERGENCY MEDICAL OVERSIGHT
TRAUMA SECTION
LEVEL I TRAUMA CENTER
APPLICATION MANUAL
INTRODUCTION

INSTRUCTIONS: To be eligible for approval as a level I trauma center, a hospital must complete this application and submit all requested information to the Department of Health, Division of Emergency Preparedness and Community Support, Trauma Section, for review no later than the close of business April 1. The following must be used to complete this application: "Florida Trauma Center Standards, DOH Pamphlet 150-9, January 2010", (standards document), and the application requirements of Chapter 395, Florida Statutes (F.S.), and Chapter 64J-2, Florida Administrative Code (F.A.C.). Please submit two hard copies of the application and two electronic copies on separate USB Flash Drives that contain the entire application, including the attachments. The application and all attachments must be typed in the order listed below and be in a binder with tabs clearly identifying each section's contents.

PHASE I - Provisional Review: No later than April 15, the department will conduct a provisional review to ensure the application is complete and that the hospital meets the standards of critical elements to become a trauma center. Hospitals with applications found to be deficient will be notified, in writing, of the deficiencies and given five working days to submit additional or clarifying information. On or before May 1, written notification will be provided to hospitals with applications found to be acceptable. These hospitals will begin to operate as a Provisional Level I Trauma Center on May 1. Each hospital denied provisional approval shall be informed of the remaining deficiencies and the right to resubmit an application during the next application cycle. Through April 30, a hospital may withdraw its trauma center application without penalty.

PHASE II - In-Depth Review: Between May 1 and June 30, the department will conduct an in-depth review of all sections of the Provisional Level I Trauma Center's application. By July 1, the department shall notify each hospital in writing of any omissions, deficiencies, or problems in their application that could result in revocation of Provisional Trauma Center status. Hospitals with deficient applications will have until midnight, September 1, to submit any additional or clarifying information to the Department of Health, Division of Emergency Preparedness and Community Support, Trauma Section. On or before October 1, the department shall complete the in-depth review and will notify each hospital in writing of any continuing deficiencies.

PHASE III - Site Visits: Between October 1 and the following May 31, each Provisional Trauma Center shall receive an on-site review by a team of out-of-state experts. By July 1, the department shall approve the trauma center based upon the recommendation of the review team, correction of deficiencies in accordance with the timeframes provided in section 64J-2.016, F.A.C., and application of the additional criteria in section 64J-2.016, F.A.C. Written notification will be sent to Provisional Trauma Centers informing them of their approval status. Hospitals approved as a level I trauma center will be issued a Certificate of Approval. Letters of denial will be sent to hospitals not approved as a trauma center, specifying the basis for denial and informing them of the next available application cycle.

Florida Trauma Center Standards, DOH Pamphlet 150-9, January 2010, the application requirements of Chapter 395, F.S., and Chapter 64J-2, F.A.C., will be used as criteria for application review.

In accordance with the provisions of section 120.57, F.S., each hospital denied provisional status or not approved as a trauma center may, within 30 days of receipt of the denial notice, request a public hearing in which to contest the findings of the department.

This manual is divided into the following five sections:

Section I General Information for Level I Trauma Center Application (DH Form 2032, January 2010).

Section II Trauma Center Approval Standards Chart (DH Form 2032-A, January 2010).

Section III Certification Statements:

a. Letter of Certification (DH Form 2032-B, January 2010).

b. Surgical Specialties Certifications (DH Form 2032-C, January 2010).

c. Non-Surgical Specialties Certifications (DH Form 2032-D, January 2010).

Section IV Attachments - please use forms provided herein:

a. General Surgeons Commitment Statement (DH Form 2032-E, January 2010).

b. General Surgeons Available for Trauma Surgical Call (DH Form 2032-F, January 2010).

c. Neurosurgeons Available for Trauma Surgical Call (DH Form 2032-G, January 2010).

d. Neurological, Pediatric Trauma and Neurological, and Neuroradiology Statements (DH Form 2032-H, January 2010).

e. Surgical Specialists On Call and Promptly Available (DH Form 2032-I, January 2010).

f. Emergency Department Physicians (DH Form 2032-J, January 2010).

g. Anesthesiologists Available for Trauma Call (DH Form 2032-K, January 2010).

h. C.R.N.A.s Available for Trauma Call (DH Form 2032-L, January 2010).

i. Non-Surgical Specialists On Call and Promptly Available (DH Form 2032-M, January 2010).

Section V Attachments - attach typed copies of the following:

a. List of physicians immediately available to the Intensive Care Unit from in-hospital, 24 hours a day. Reference Standard VII "Intensive Care Unit and Pediatric Intensive Care Unit" of the standards document.

b. Burn unit patient transfer agreement, where applicable. Reference Standard XIII "Organized Burn Care" of the standards document.

c. Spinal cord injured patient acute care center and rehabilitation center transfer agreements, where applicable. Reference Standard XIV "Acute Spinal Cord and Brain Injury Management Capability" of the standards document.

d. Copies of current and planned internal and external trauma specific continuing education training programs. Please provide a list of all trauma specific continuing education courses presented by your facility in the last 12 months. This list shall specify the name and date of courses and participants. Please also submit a continuing education plan that includes trauma specific courses for the next 12 months. This plan

shall specify the subject and dates of these courses (even if they are tentative at this time) and expected participants; for example, nurses, staff and community physicians, and allied health personnel. Reference Standard VIII "Training and Continuing Education Programs" of the standards document.

e. Detailed description of your system of trauma alert patient care from patient arrival to final disposition. Please include the following: (a) description of your trauma team (who composes it and their positions); (b) how and by whom the team is activated; (c) which team members are in-hospital, which are on call; and (d) time required to initiate activation of the team. The description must reflect that the general (trauma) surgeon will depart without delay for the trauma center upon notification of a trauma alert. You may use trauma care protocols and flow diagrams where applicable. Reference Standard II "Trauma Service," Standard III "Surgical Services," Standard IV "Non-Surgical Services," and Standard V "Emergency Department" of the standards document.

f. Quality management (QM) protocols as required in Standard XVIII "Quality Management" section B of the standards document.

g. QM plan.

SECTION I

TRAUMA CENTER
GENERAL INFORMATION

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY PREPAREDNESS AND COMMUNITY SUPPORT
BUREAU OF EMERGENCY MEDICAL OVERSIGHT
TRAUMA SECTION

GENERAL INFORMATION FOR LEVEL I TRAUMA CENTER APPLICATION

1. Name of Hospital _____

2. Street Address _____

3. Mailing Address _____

4. City, State, Zip Code _____

5. Chief Executive Officer _____

   Telephone Number ( ) _____

   Fax Number ( ) _____

   Email Address _____

6. Contact Person for Application (if other than Trauma Program Manager) _____

   Telephone Number ( ) _____

   Fax Number ( ) _____

   Email Address _____

7. Trauma Medical Director _____

   Telephone Number ( ) _____

   Fax Number ( ) _____

   Email Address _____

8. Trauma Program Manager _____

   Telephone Number ( ) _____

   Fax Number ( ) _____

   Email Address _____

9. Emergency Department Medical Director _____

Telephone Number ( ) _____

Fax Number ( ) _____

Email Address _____

SECTION II

LEVEL I TRAUMA CENTER STANDARDS SUMMARY CHART

INSTRUCTIONS: This chart serves as a summary of the trauma center standards of critical elements and is provided as part of the trauma center application to document compliance of individual standards. This chart must be used in conjunction with DOH Pamphlet 150-9, entitled Trauma Center Standards, January 2010, to determine the complete requirements, including interpretations of the standards.

Please check "Yes" or "No" next to each standard in order to verify compliance. Where attachments are requested, please include them with Section V of this application.

Note: The numbering in this summary corresponds to the numbering in the standards document.

STANDARD I -- ADMINISTRATIVE

			Yes	No
A.	Demonstrated commitment to trauma care.			
	1.	A board of directors' resolution of commitment of hospital financial, human, and physical resources to treat all trauma patients at the level of hospital's approval, regardless of color creed, sex, nationality, place of residence, or financial class. (Attach)		
	2.	A board of directors' resolution of commitment to participate in the state regional trauma system and the local or regional trauma system, if one exists. (Attach if applicable)		
	3.	A trauma budget that provides sufficient support to the trauma service and program within the hospital. (Attach)		
	4.	Institution of procedures to document and review all transfers with neighboring hospitals and trauma centers for transfers into and out of the hospital. (Attach)		
	5.	Policies and procedures for the maintenance of the services essential to a trauma center and system. (Attach)		
	6.	Providing patient care data as requested by the department or its agent.		
	7.	Formal written patient transfer agreements with neighboring hospitals and trauma centers. (Attach)		
E.	The trauma service medical director is responsible for credentialing and attesting to the medical ability of all personnel who provide trauma services. Appointment or removal of personnel from the trauma service shall be done by the trauma service medical director pursuant to procedures, policies, or bylaws of the hospital.			
F.	The hospital shall ensure that the procedures, policies, or bylaws address circumstances in which the trauma service medical director determines that an attending physician's actions compromise the health, safety, or welfare of trauma patients. In such case, procedures, policies, or bylaws shall address options such as temporary or permanent removal of the physician from the trauma service, or other appropriate remedial measures. (Attach pertinent bylaws)			

STANDARD II -- TRAUMA SERVICE

			Yes	No
A.	Organizational Requirements -- Dedicated and defined service. (Attach organizational chart)			
	1.	A designated medical director for the trauma service. (Attach current CV and job description)		
	2.	A designated trauma program manager for the trauma service. (Attach current CV and job description)		
	3.	A trauma registrar for the trauma service. (Attach current CV and job description)		
	4.	At least one qualified trauma surgeon (as described in Standard III.A) to be in-hospital and on primary trauma call at all times to provide trauma service care. (Attach call schedule for one month)		
	5.	At least one qualified trauma surgeon (as described in Standard III.A) to be on backup trauma call at all times to provide trauma service care.		
	6.	At least one qualified pediatric trauma surgeon for the trauma service (as described in Standard III.A.3.b).		
B.	Administrative Requirements -- The trauma service medical director shall ensure the following:			
	1.	The following physicians participating on the trauma service meet and maintain the qualifications, certifications, and trauma-related continuing medical education (CME) data as required in Standards III.A and B and Standard V.B:		
		a. Pediatric and general trauma surgeons.		
		b. Emergency physicians.		
	5.	Evidence is on file of active membership of the trauma service medical director and the trauma program manager in the local or regional trauma agency, or local health planning council or advisory group if no trauma agency exists. (Attach copy of minutes)		
	6.	A written plan is on file that describes the hospital's interaction with the local or regional trauma agency, if one exists, and other county and regional medical response or treatment resources during disaster and mass casualty situations. (Attach disaster plan)		
	9.	The trauma center shall provide, within the facility, pediatric trauma patient care services, from emergency department admission through rehabilitation, that are separate and distinct from adult trauma patient care services.		
C.	Medical and Patient Care Requirements			
	1.	The trauma service medical director shall ensure that patient care protocols exist for a minimum of the following departments: (Attach)		
		a. Trauma Resuscitation Area.		
		b. Intensive Care Unit and Pediatric Intensive Care Unit.		
		c. Operating Room and Post-Anesthesia Recovery/Post-Anesthesia Care Unit.		
		d. Medical Surgical Unit.		

			Yes	No
	2.	The trauma service medical director shall ensure that policies and protocols are developed for a minimum of the following: (Attach)		
	a.	Priority admission status for trauma patients.		
	b.	Patient transfers into and out of the hospital.		
	3.	The trauma service medical director shall approve all trauma-related patient care protocols before implementation.		
	4.	The trauma service medical director in coordination with the trauma program manager shall monitor compliance with trauma-related protocols through the trauma quality management process.		
D.	Qualifications of Leadership Staff -- At a minimum, this evidence shall include the following:			
	1.	Trauma Service Medical Director		
	a.	Proof of board certification in general surgery. (Attach)		
	b.	Documentation that the hospital granted the medical director full and unrestricted privileges to provide general surgical and trauma care surgical services for adult and pediatric patients. (Attach)		
	c.	Documentation that the medical director manages a minimum of 28 trauma cases per year (average of seven trauma cases per quarter), at least eight of which are pediatric if the medical director manages pediatric trauma patients. (Attach)		
	d.	Documentation of a minimum of ten Category I CME credits every year in trauma-related topics, five of which shall be in pediatric trauma if the medical director manages pediatric trauma patients. (Attach)		
	e.	A written attestation from the Chief of Neurosurgery indicating that the trauma service medical director is capable of providing initial stabilization measures and instituting diagnostic procedures for patients, both adult and pediatric, with neural trauma. (Attach)		
	f.	Current ATLS instructor certification. (Attach)		
	2.	Trauma Program Manager		
	a.	Documentation of current Florida Registered Nurse licensure. (Attach)		
	b.	Documentation of current Emergency Nurses Association Trauma Nursing Core Course (TNCC) training or equivalent. (Attach)		
	c.	Documentation of a minimum of ten contact hours every year in trauma-related topics, five of which must be in pediatric trauma. (Attach)		

STANDARD III -- SURGICAL SERVICES -- STAFFING AND ORGANIZATION

			Yes	No
A.	General or Pediatric Surgery			
	1.	Minimum of five qualified trauma surgeons.		

				Yes	No
2.	Each trauma surgeon who is a member of the trauma service and takes trauma call shall sign the Department of Health's General Surgeons Commitment Statement.				
3.	Trauma surgeon qualifications.				
	a.	For a general surgeon:			
		(1)	Proof of board certification or actively participating in the certification process with a time period set by each specialty board in general surgery, or proof of meeting the definition of alternate criteria. (Attach)		
		(2)	Documentation that the hospital granted the general surgeon full and unrestricted privileges to provide general surgical and trauma care surgical services for adult and pediatric patients. (Attach)		
		(3)	Documentation that the general surgeon manages a minimum of 28 trauma cases per year (average of seven trauma cases per quarter), at least eight of which are pediatric if the general surgeon manages pediatric trauma patients. (Attach)		
		(4)	Documentation of a minimum of ten Category I CME credits every year in trauma-related topics, five of which shall be in pediatric trauma if the general surgeon manages pediatric trauma patients. (Attach)		
		(5)	A written attestation from the Chief of Neurosurgery indicating that the general surgeon is capable of providing initial stabilization measures and instituting diagnostic procedures for patients, both adult and pediatric, with neural trauma. (Attach)		
		(6)	Current ATLS provider certificate. (Attach)		
	b.	For a pediatric surgeon:			
		(1)	Proof of board certification or actively participating in the certification process with a time period set by each specialty board in pediatric surgery, or proof of meeting the definition of alternate criteria. (Attach)		
		(2)	Documentation that the hospital granted the pediatric surgeon full and unrestricted privileges to provide general surgical and trauma care surgical services specific to pediatric patients. (Attach)		
		(3)	Documentation that the pediatric surgeon manages a minimum of 12 pediatric trauma cases per year (average of three trauma cases per quarter). (Attach)		
		(4)	Documentation of a minimum of ten Category I CME credits every year in trauma-related topics, five of which shall be in pediatric trauma. (Attach)		
		(5)	A written attestation from the Chief of Neurosurgery indicating that the pediatric surgeon is capable of providing initial stabilization measures and instituting diagnostic procedures for pediatric patients with neural trauma. (Attach)		

						Yes	No
				(6)	Current ATLS provider certification. (Attach)		
4.	Senior surgical residents (PGY-4 or above) may fill the in-hospital general surgical requirement if the trauma service medical director ensures the following:						
	a.	A qualified general surgeon (or pediatric surgeon for pediatric patients) is on trauma call and shall arrive promptly at the trauma center when summoned.					
	b.	The trauma service medical director attests in writing that each resident is capable of the following:					
			(1)	Providing appropriate assessment and responses to emergent changes in patient condition.			
			(2)	Instituting initial diagnostic procedures.			
			(3)	Initiating surgical procedures.			
	c.	When a trauma alert patient is identified, the attending trauma surgeon shall be summoned and take an active role by participating in patient care during the resuscitation.					
	d.	The attending trauma surgeon shall also accompany the senior surgical resident to the operating room.					
	e.	Each general surgical resident has current ATLS provider certification. (Attach)					
B.	Neurological Surgery						
1.	Minimum of one qualified neurosurgeon to provide in-hospital trauma coverage 24 hours a day at the trauma center. (Attach call schedule for one month)						
2.	Qualifications of each neurosurgeon who takes trauma call.						
	a.	Proof of board certification or actively participating in the certification process with a time period set by each specialty board in neurosurgery, or proof of meeting the definition of alternate criteria. (Attach)					
	b.	Documentation that the hospital has granted the neurosurgeon privileges to provide neurosurgical and trauma care services for adult and pediatric patients. (Attach)					
3.	Senior neurosurgical residents, PGY-2 or above, may fill the in-hospital neurosurgeon requirement only if the trauma service medical director and the Chief of Neurosurgery ensure the following:						
	a.	An attending neurosurgeon is on trauma call and available to arrive promptly at the trauma center to provide stabilization, diagnostic procedures, or definitive operative care.					
	b.	The trauma service medical director and the Chief of Neurosurgery attest in writing that the senior neurosurgical resident is capable of the following:					
			(1)	Providing appropriate assessment and responses to emergent changes in patient condition.			
			(2)	Instituting initial diagnostic procedures.			
	c.	There is evidence on file that each resident has completed at least two years of neurosurgical training. (Attach)					

			Yes	No
	4.	General trauma surgeons (or the senior surgical residents, PGY-4 or above, who are fulfilling the in-hospital requirement as described in Standard III.A.4) may fill the in-hospital neurosurgeon requirement only if the trauma service medical director and the Chief of Neurosurgery ensure the following:		
	a.	An attending neurosurgeon is on trauma call and shall arrive promptly at the trauma center when summoned.		
	b.	The Chief of Neurosurgery shall provide written protocols for the general trauma surgeons regarding the initiation of neurologic resuscitation and evaluation for head and spinal cord injuries. The protocols shall also include criteria for immediate summoning of or consultation with the attending on-call neurosurgeon. (Attach protocols)		
C.		Surgeons in the following specialties shall be available to arrive promptly at the trauma center when summoned:		
	1.	Cardiac surgery.		
	2.	Hand surgery.		
	3.	Microsurgery capabilities.		
	4.	Obstetric/gynecologic surgery.		
	5.	Ophthalmic surgery.		
	6.	Oral/maxillofacial surgery.		
	7.	Orthopedic surgery.		
	8.	Otorhinolaryngologic surgery.		
	9.	Plastic surgery.		
	10.	Thoracic surgery.		
	11.	Urologic surgery.		
D.		All surgeons staffing the services listed in items C.1-11 above shall be board certified or actively participating in the certification process with a time period set by each specialty board for certification in their respective specialties, and granted privileges by the hospital to care for adult and pediatric patients.		

STANDARD IV -- NON-SURGICAL SERVICES -- STAFFING AND ORGANIZATION

			Yes	No
A.		Anesthesia -- An anesthesiologist shall be in-hospital and promptly available for trauma patient care 24 hours a day. The anesthesiologist shall be board certified or actively participating in the certification process with a time period set by each specialty board and have privileges from the hospital to provide anesthesia and trauma care services for adult and pediatric patients. A certified registered nurse anesthetist (C.R.N.A.) or a senior anesthesia resident (CA-3 or above) may, however, fill the in-hospital anesthesiologist requirement only if the trauma service medical director ensures the requirements in the standards document.		
B.		The following non-surgical specialties shall be available 24 hours a day to arrive promptly at the trauma center when summoned:		
	1.	Cardiology.		
	2.	Gastroenterology.		

			Yes	No
	3.	Hematology.		
	4.	Infectious diseases.		
	5.	Internal medicine.		
	6.	Nephrology.		
	7.	Pathology.		
	8.	Pediatrics.		
	9.	Psychiatry.		
	10.	Pulmonary medicine.		
	11.	Radiology.		
C.	All specialists staffing the services listed in B.1-11 above shall be board certified or actively participating in the certification process with a time period set by each specialty board in their respective specialties, and granted medical staff privileges by the hospital to care for adult and pediatric patients.			

STANDARD V -- EMERGENCY DEPARTMENT

				Yes	No
A.	Facility Requirements				
	1.	An easily accessible and identifiable resuscitation area designated for trauma alert patients. This area shall be large enough to allow assembly of the full trauma team. (Attach schematic floor plan)			
	2.	Resources, staff, and equipment necessary to treat the pediatric trauma patient.			
	3.	The trauma resuscitation area shall be of adequate size and contain adequate trauma care equipment and supplies to simultaneously perform at least two multi-system trauma alert patient resuscitations.			
	4.	Security measures in place in the resuscitation area designed to protect the life and well-being of assigned trauma center staff, patients, and families.			
	5.	Facilities to accommodate the simultaneous unloading of two EMS ground units.			
	6.	There shall be a helicopter landing site in close proximity to the resuscitation area. Close proximity means that the interval of time between the landing of the helicopter and the transfer of the patient into the resuscitation area will be such that no harmful effect on the patient's outcome results. All helicopter landing sites shall also meet the following requirements: (Attach schematic diagram)			
		a.	The site shall be licensed by the Florida Department of Transportation. (Attach)		
		b.	Use of the air space shall be approved by the Federal Aviation Administration. (Attach)		
		c.	Documentation shall be on file with the trauma service indicating that the trauma center develops and maintains protocols and provides training during employee orientation regarding the safe loading and unloading of patients from a helicopter, as well as precautions to ensure the safety of staff or bystanders while in the vicinity of the aircraft.		

				Yes	No
B.	Physician Requirements				
	1.	Designated Emergency Department Medical Director			
		a.	Proof of board certification in emergency medicine. (Attach)		
		b.	Documentation that the hospital granted privileges to the emergency department medical director to provide trauma and other emergency care services for adult and pediatric patients. (Attach)		
		c.	Documentation of a minimum of five Category I CME credits every year in trauma-related topics, at least two of which are in pediatric trauma. (Attach)		
		d.	Documentation of a full-time practice in emergency medicine (may include both administrative and patient care hours). (Attach)		
		e.	Current ATLS provider certification. (Attach)		
	2.	Emergency Physicians -- At least one emergency physician is on duty in the emergency department 24 hours a day to cover adult and pediatric trauma patient care services. (Attach call schedule for one month)			
		a.	During assigned shifts, must be physically present in-hospital to meet all trauma alert patients in the trauma resuscitation area at the time of the trauma alert patient's arrival.		
		b.	During assigned shifts, must assume trauma team leadership if the trauma surgeon on trauma call is not physically present at the time of the trauma alert patient's arrival in the trauma resuscitation area.		
		c.	During assigned shifts, must transfer the care of the trauma patient to the attending trauma surgeon upon his or her arrival in the resuscitation area.		
	3.	Qualifications of the emergency physicians working in the resuscitation area:			
		a.	Certification and experience		
			(1) Proof of board certification or actively participating in the certification process with a time period set by each specialty board in emergency medicine, or proof of meeting the definition of alternate criteria. (Attach) or		
			(2) Board certification or actively participating in the certification process with a time period set by each specialty board in a primary care specialty and a written attestation by the emergency department medical director that the physician has worked as a full-time emergency physician for at least three out of the last five years. (Attach)		
		b.	Documentation of a minimum of five Category I CME credits every year in trauma-related topics, at least two of which are in pediatric trauma if the emergency physician cares for pediatric trauma patients. (Attach)		
		c.	Documentation that the hospital granted privileges to the emergency physician to provide trauma and other emergency care services for adult and pediatric patients. (Attach)		
		d.	Current ATLS provider certification. (Attach)		

				Yes	No
4.	For emergency physicians who care for only pediatric trauma patients, the evidence shall include the following:				
	a.	Certification and experience			
		(1)	Proof of board certification or actively participating in the certification process with a time period set by each specialty board in pediatric emergency medicine, or proof of meeting the definition of alternate criteria. (Attach)		
		(2)	Board certification in a primary care specialty or emergency medicine and a written attestation by the emergency department medical director that the physician has worked as a full-time emergency physician for at least three out of the last five years. (Attach)		
	b.	Documentation of a minimum of five Category I CME credits every year in trauma-related topics, at least two of which are in pediatric trauma. (Attach)			
	c.	Documentation that the hospital granted privileges to the emergency physician to provide trauma and other emergency care services for pediatric patients. (Attach)			
	d.	Current ATLS provider certification. (Attach)			
5.	A PGY-3 emergency medicine chief resident or emergency medicine fellow may fill the requirements of meeting trauma alert patients in the resuscitation area only if the emergency department medical director ensures the following:				
	a.	An attending emergency physician, who meets the qualifications delineated in items B.2 and 3, is in the emergency department 24 hours per day.			
	b.	The trauma medical director and the emergency department medical director attest in writing that each participating resident or fellow is capable of the following:			
		(1)	Providing appropriate assessment and responses to emergent changes in patient condition.		
		(2)	Instituting initial diagnostic procedures.		
		(3)	Providing definitive emergent care.		
	c.	Documentation on file indicating that each PGY-3 resident or fellow has completed at least 24 months of emergency medicine experience and has current ATLS provider certification. (Attach)			
C.	Resuscitation Area Nursing and Support Personnel Staffing Requirements				
1.	Resuscitation area nursing staff				
	a.	At a minimum, two nurses (R.N.s) per shift shall be in-hospital and taking primary assignment for the resuscitation area. (Attach nursing staffing plan)			
	b.	All resuscitation area nurses shall fulfill all initial and recurring training requirements as delineated in Standard VIII within the time frames provided.			

			Yes	No
D.	Resuscitation Area Documentation Requirements			
1.	The trauma team shall use a trauma flow sheet of one or more pages to document patient care in the resuscitation area. (Attach)			
2.	The trauma flow sheet shall provide a sequential account of the following:			
a.	The time EMS called trauma alert.			
b.	The time of the trauma alert patient's arrival in the resuscitation area.			
c.	The prehospital or hospital reason for the trauma alert being called.			
d.	The time of arrival for each trauma team member and physician consultant.			
e.	Serial physiological measurements and neurological status.			
f.	All invasive procedures performed and results.			
g.	Laboratory tests.			
h.	Radiological procedures.			
i.	The time of disposition and the patient's destination from the resuscitation area.			
j.	Complete nursing assessment.			
k.	Weight for pediatric trauma patients.			
l.	Immobilization measures.			
m.	Total burn surface area and fluid resuscitation calculations for burn patients.			
E.	Emergency Department Responsibilities			
4.	The trauma team shall include, at a minimum, the following:			
a.	A trauma surgeon (as team leader).			
b.	An emergency physician.			
c.	At least two trauma resuscitation area registered nurses.			

STANDARD VI -- OPERATING ROOM AND POST-ANESTHESIA RECOVERY AREA

			Yes	No
A.	Operating Room			
1.	At least one adequately staffed operating room immediately available for adult and pediatric trauma patients 24 hours a day. (Attach policy)			
2.	A second adequately staffed operating room available within 30 minutes after the primary operating room is occupied with an adult or pediatric trauma patient.			
3.	The operating team shall consist minimally of the following:			
a.	One scrub nurse or technician.			
b.	One circulating registered nurse.			
c.	One anesthesiologist immediately available.			

			Yes	No
B.	Post-Anesthesia Recovery (PAR)			
	1.	The PAR area (the surgical intensive care unit is acceptable) is adequately staffed with registered nurses and other essential personnel 24 hours a day. (Attach nursing staffing plan)		
	2.	A physician credentialed by the hospital to provide care in the ICU or emergency department shall be in-hospital and available to respond immediately to the PAR for care of adult and pediatric trauma patients 24 hours a day.		

STANDARD VII -- INTENSIVE CARE UNIT (ICU) AND PEDIATRIC INTENSIVE CARE UNIT (PICU)

				Yes	No
B.	Adult ICU				
	1.	Physician Requirements:			
		a.	Trauma medical director or trauma surgeon designee is responsible for adult trauma patient care in the ICU.		
		b.	An attending trauma surgeon may transfer primary responsibility for a stable adult patient with a single-system injury (for example, neurological) from the trauma service if it is mutually acceptable to the attending trauma surgeon and the surgical specialist of the accepting service.		
		c.	The in-hospital trauma surgeon, or the general surgical resident fulfilling the in-hospital requirement (See Standard III.A.4), shall be available from within the hospital to arrive promptly for adult trauma patients in the ICU for emergent situations when the trauma service medical director or trauma surgeon designee is not available.		
		d.	The trauma center shall track by way of the trauma registry all adult trauma patients, whether under the primary responsibility of the trauma service or of another surgical or non-surgical service, through the quality management process to evaluate the care provided by all health care disciplines.		
	2.	Nursing Requirements			
		a.	The ratio of nurses to trauma patients in the ICU shall be a minimum of 1:2, and shall be increased above this as dictated by patient acuity. (Attach nursing staffing plan)		
		b.	The ICU nursing staff shall satisfy all initial and recurring training requirements, as listed in Standard VIII, in the time frames provided.		
C.	Pediatric ICU				
	1.	Physician Requirements			
		a.	The trauma medical director or trauma surgeon designee is responsible for pediatric trauma patient care in the PICU.		

			Yes	No
	b.	An attending trauma surgeon or pediatric surgeon may transfer primary responsibility for a stable pediatric patient with a single-system injury (for example, neurological) from the trauma service if it is mutually acceptable to the attending trauma surgeon or pediatric surgeon and the surgical specialist of the accepting service.		
	c.	The in-hospital trauma surgeon, or the general surgical resident fulfilling the in-hospital requirement (See Standard III.A.4), shall be available from within the hospital to arrive promptly for pediatric trauma patients in the PICU for emergent situations when the trauma service medical director or trauma surgeon designee is not available.		
	d.	The trauma center shall track by way of the trauma registry all pediatric trauma patients, whether under the primary responsibility of the trauma service or of another surgical or non-surgical service, through the quality management process to evaluate the care provided by all health care disciplines.		
2.	Nursing Requirements			
	a.	The ratio of nurses to trauma patients in the PICU shall be a minimum of 1:2, and shall be increased above this as dictated by patient acuity. (Attach nursing staffing plan)		
	b.	The PICU nursing staff shall satisfy all initial and recurring training requirements, as listed in Standard VIII, in the time frames provided.		
D.	Nursing documentation in the ICU and PICU shall be on a 24-hour patient flow sheet. (Attach)			
E.	There shall be immediate access to clinical laboratory services.			

STANDARD VIII -- TRAINING AND CONTINUING EDUCATION PROGRAMS

		Yes	No
A.	Registered nurses assigned to following departments shall obtain the specified number of trauma-related contact hours: (Attach)		
1.	ED/trauma resuscitation area -- 16 contact hours every two years.		
2.	Operating room and post-anesthesia recovery -- eight contact hours every two years.		
3.	Intensive care unit and pediatric intensive care unit -- eight contact hours every two years.		
4.	Medical surgical/step down unit for both adult and pediatric -- eight contact hours every two years.		
5.	Rehabilitation unit -- eight contact hours every two years.		
6.	Burn unit -- eight contact hours every two years.		

		Yes	No
B.	Licensed practical nurses assigned to the above departments shall complete eight contact hours every two years. (Attach)		
C.	Paramedics assigned to the above departments shall complete four contact hours of trauma-related continuing education every two years. (Attach if applicable)		

STANDARD IX -- EQUIPMENT

			Yes	No
A.	Trauma Resuscitation Area			
	1.	Airway control and ventilation equipment, including various sizes of laryngoscopes and endotracheal tubes, bag valve mask resuscitator, mechanical ventilator oxygen masks and cannulae, and oxygen.		
	2.	Autotransfusion.		
	3.	Cardiopulmonary resuscitation cart, including emergency drugs and equipment.		
	4.	Doppler monitoring capability.		
	5.	Electrocardiograph/oscilloscope/defibrillator.		
	6.	Monitoring equipment for blood pressure and pulse and an electrocardiogram (ECG).		
	7.	Pacing capability.		
	8.	Pulse oximetry.		
	9.	Skeletal traction devices.		
	10.	Standard devices and fluids for intravenous (IV) administration.		
	11.	Sterile surgical sets for airway, chest, vascular access, diagnostic peritoneal lavage, and burr hole capability.		
	12.	Suction devices and nasogastric tubes.		
	13.	Telephone and paging equipment for priority contact of trauma team personnel.		
	14.	Thermal control devices for patients, IV fluids, and environment.		
	15.	Two-way radio communication with prehospital transport vehicles (radio communications shall conform to the State EMS Communications Plan).		
B.	Operating Room			
	1.	Airway control and ventilation equipment, including various sizes of laryngoscopes and endotracheal tubes, bag valve mask resuscitator, mechanical ventilator suction devices, oxygen masks and cannulae, and oxygen.		
	2.	Anesthesia monitoring equipment.		
	3.	Autotransfusion.		
	4.	Cardiopulmonary bypass capability.		
	5.	Cardiopulmonary resuscitation cart, including emergency drugs and equipment.		
	6.	Craniotomy/burr hole and intracranial monitoring capabilities.		

			Yes	No
	7.	Endoscopes.		
	8.	Invasive hemodynamic monitoring and monitoring equipment for blood pressure, pulse, and ECG.		
	9.	Operating microscope.		
	10.	Orthopedic equipment for fixation of pelvic, longbone, and spinal fractures and fracture table.		
	11.	Pacing capability.		
	12.	Standard devices and fluids for IV administration.		
	13.	Thermal control devices for patients, IV fluids, and environment.		
	14.	X-ray capability.		
C.	Post-Anesthesia Recovery			
	1.	Airway control and ventilation equipment, including various sizes of laryngoscopes and endotracheal tubes, bag valve mask resuscitator, mechanical ventilator suction devices, oxygen masks and cannulae, and oxygen.		
	2.	Autotransfusion.		
	3.	Cardiopulmonary resuscitation cart, including emergency drugs and equipment.		
	4.	Intracranial pressure monitoring.		
	5.	Invasive hemodynamic monitoring and monitoring equipment for blood pressure, pulse, and ECG.		
	6.	Pacing capability.		
	7.	Pulse oximetry.		
	8.	Standard devices and fluids for IV administration.		
	9.	Sterile surgical sets for airway and chest.		
	10.	Thermal control devices for patients and IV fluids.		
D.	Intensive Care Unit and Pediatric Intensive Care Unit			
	1.	Airway control and ventilation equipment, including various sizes of laryngoscopes and endotracheal tubes, bag valve mask resuscitator, mechanical ventilator suction devices, oxygen masks and cannulae, and oxygen.		
	2.	Auto transfusion.		
	3.	Cardiopulmonary resuscitation cart, including emergency drugs and equipment.		
	4.	Compartment pressure monitoring devices.		
	5.	Intracranial pressure monitoring capabilities.		
	6.	Invasive hemodynamic monitoring.		
	7.	Orthopedic equipment for the management of pelvic, longbone, and spinal fractures.		
	8.	Pacing capabilities.		
	9.	Pulse oximetry.		

			Yes	No
	10.	Scales.		
	11.	Standard devices and fluids for IV administration.		
	12.	Sterile surgical sets for airway and chest.		
	13.	Thermal control devices for patients, IV fluids, and environment.		
E.	Medical Surgical Unit			
	1.	Airway control and ventilation equipment, including laryngoscopes, endotracheal tubes of all sizes, bag-mask resuscitator, and sources of oxygen.		
	2.	Cardiopulmonary resuscitation cart, including emergency drugs and equipment.		
	3.	Standard devices and fluids for IV administration.		
	4.	Suction devices.		

STANDARD X -- LABORATORY SERVICES

				Yes	No
A.	Service Capabilities -- The trauma centershall have the following laboratory capabilities for adult and pediatric trauma alert patients available in-hospital 24 hours per day:				
	1.	Services for the prompt analysis of the following:			
		a.	Blood, urine, and other body fluids.		
		b.	Blood gases and pH determination within five minutes 90 percent of the time.		
		c.	Coagulation studies.		
		d.	Drug and alcohol screening.		
		e.	Microbiology.		
		f.	Serum and urine osmolality.		
	2.	Appropriately staffed blood bank. The blood bank shall, at a minimum, be capable of providing the following:			
		a.	Blood typing, screening, and cross-matching.		
		b.	Platelets and fresh frozen plasma.		
		c.	At least 10 units of type "O" blood, three of which shall be "O negative."		
	3.	Written protocols ensuring that trauma patients receive priority over routine laboratory tests. (Attach)			
B.	A laboratory technician shall be available in-hospital 24 hours per day to conduct laboratory studies for trauma alert patients.				

STANDARD XII -- RADIOLOGICAL SERVICES

				Yes	No
A.	Service Capabilities -- Available in-hospital 24 hours per day:				
	1.	Angiography (of all types) with a maximum response time until the start of the procedure of 60 minutes.			
	2.	Computerized tomography (CT).			
	3.	Routine radiological studies.			
B.	Staffing Requirements -- Available 24 hours per day:				
	1.	A radiologist, board certified or actively participating in the certification process with a time period set by each specialty board, and granted privileges by the hospital to provide radiological services for adult and pediatric patients, shall be in-hospital and promptly available 24 hours a day. A chief radiology resident may fill the in-hospital requirement only if the trauma medical director ensures the following:			
		a.	A staff radiologist is on trauma call and available to arrive promptly at the trauma center when summoned.		
		b.	The trauma medical director and the Chief of Radiology attest in writing that each participating resident is capable of the following:		
			(1) Authorizing any radiological studies required for adult and pediatric trauma alert patients.		
			(2) Providing appropriate evaluation of adult and pediatric trauma alert patient radiological studies.		
	2.	A CT technician shall be in-hospital 24 hours a day.			
	3.	A radiological technician shall be available in-hospital 24 hours per day.			
C.	CT Scanner Requirements				
	1.	At least one CT scanner shall be available for trauma alert patients, and be located in the same building as the resuscitation area.			
	2.	If the trauma center has only one CT scanner, a written plan shall be in place describing the steps to be taken if the apparatus is in use or becomes temporarily inoperable. (Attach)			

STANDARD XIII -- ORGANIZED BURN CARE

		Yes	No
A.	The trauma center shall have written policies and procedures for triage, assessment, stabilization, emergency treatment, and transfer (either into or out of the facility) of burn patients. Policies and procedures shall also be written regarding in-hospital management, including rehabilitation, of burn patients. (Attach)		

STANDARD XIV -- ACUTE SPINAL CORD AND BRAIN INJURY MANAGEMENT CAPABILITY

		Yes	No
A.	The trauma center shall have written policies and procedures for triage, assessment, stabilization, emergency treatment, and transfer (either into or out of the facility) for brain or spinal cord injured patients. Policies and procedures shall also be written regarding in-hospital management, including rehabilitation, for brain or spinal cord injured patients. (Attach)		

STANDARD XV -- ACUTE REHABILITATIVE SERVICES

			Yes	No
B.	The trauma medical director or trauma program manager shall ensure that trauma patients have an evaluation by any or all of the following (as appropriate to the patient's injury) within 7 days of inpatient admission:			
	1.	Attending trauma surgeon, neurosurgeon, neurologist, or orthopedic surgeon.		
	2.	Neuropsychologist.		
	3.	Nursing personnel may include the following:		
		a. Trauma program manager or designee.		
		b. Clinical nurse specialist.		
		c. Rehabilitation nurse.		
	4.	Occupational therapist.		
	5.	Physiatrist or medical director of the rehabilitation services department.		
	6.	Physical therapist.		
	7.	Speech therapist.		

STANDARD XVI -- PSYCHOSOCIAL SUPPORT SYSTEMS

		Yes	No
A.	The trauma center shall have written policies and protocols to provide mental health services, child protective services, and emotional support to trauma patients or their families. At a minimum, the policies and protocols shall include qualified personnel to provide the services and require that the personnel shall arrive promptly at the trauma center when summoned. (Attach)		

STANDARD XVII -- OUTREACH PROGRAMS

		Yes	No
B.	Consultations or feedback to EMS or the transferring hospital regarding any patient admitted to the intensive care unit when performance improvement issues related to prehospital care are applicable.		
C.	The trauma center should provide 24-hour availability of telephone consultation with members of the hospital's trauma team and physicians of the community and outlying areas.		

			Yes	No
E.	Evidence of a minimum of 10 multidisciplinary conferences conducted per year to provide trauma case review for the purpose of case management, education, and correction of system issues for both prehospital and in-hospital. The case review must include at least one adult and one pediatric trauma patient when appropriate.			
1.	The conference shall include the review of the following:			
a.	The local and regional emergency medical service system.			
b.	Individual case management.			
c.	The trauma center or system.			
d.	Solution of specific problems, including organ procurement and donation.			
e.	Trauma care education.			
2.	In order to be considered a multidisciplinary conference, there shall be at least one representative from the following departments: :			
a.	Trauma service.			
b.	Emergency department.			
c.	Neurosurgery.			
d.	Orthopedics.			
e.	Nursing.			
f.	Social work.			
g.	Rehabilitation medicine.			
h.	Laboratory.			
i.	X-ray.			
j.	Prehospital providers.			
k.	Hospital administration.			

STANDARD XVIII -- QUALITY MANAGEMENT

			Yes	No
A.	Written evidence on file indicating the governing body's commitment to the trauma quality improvement program. This evidence shall include the following:			
1.	The trauma medical director must have authority and administrative support to implement changes related to the process of care and outcomes across multiple specialty departments.			
2.	A clearly defined performance improvement program for the trauma population that is integrated into the hospital-wide program. The trauma program's monitoring and evaluation process must show identification of process/outcome issues, corrective actions taken, and loop closure, when applicable, for evaluations of the desired effects.			

				Yes	No
B.	Written evidence on file indicating an active and effective trauma quality improvement program. This evidence shall include procedures and mechanisms for at least the following:				
	1.	Population of cases for review -- The trauma medical director and trauma program manager shall review all trauma patient records from the following categories:			
		a.	All trauma alert cases admitted to the hospital (patients identified by the state trauma scorecard criteria in Rules 64J-2.004 and 64J-2.005, Florida Administrative Code).		
		b.	Critical or intensive care unit admissions for traumatic injury.		
		c.	All operating room admissions for traumatic injury (excluding same day discharges or isolated, non-life threatening orthopedic injuries).		
		d.	Any critical trauma transfer into or out of the hospital.		
		e.	All in-hospital traumatic deaths, including deaths in the trauma resuscitation area.		
	2.	Process/outcome indicators -- The facility shall monitor a total of ten indicators relevant to process or outcome measures.			
		a.	The facility must monitor three state-required indicators relevant to process and outcome.		
		b.	The facility must identify and monitor seven indicators relevant to its respective facility for a period of six months and submit these indicators to the Department of Health.		
	3.	Evaluation of cases -- The trauma medical director or trauma program manager shall evaluate each case identified by one of the indicators to determine whether the case should be referred to the TQM committee for further review.			
	4.	Committee discussion and action -- The members of the TQM committee shall review and discuss each case referred by the trauma service medical director or trauma program manager.			
	5.	Resolution and follow-up -- The TQM committee shall evaluate and document the effectiveness of action taken to ensure problem resolution, improvements in patient care, or improved patient outcomes.			
C.	The TQM committee shall meet a minimum of 10 times per year to review trauma cases referred by the trauma service medical director or trauma program manager, including cases identified by the indicators listed in and other cases with quality of care concerns, systems issues, morbidity, or mortality.				
D.	The trauma quality management committee shall be composed of at least the following persons:				
	1.	Trauma medical director (as chairperson).			
	2.	Trauma program manager.			
	3.	Medical director of emergency department or emergency physician designee.			

		Yes	No
	4. Trauma surgeon, other than the trauma medical director.		
	5. Surgical specialist other than trauma surgeon, such as neurosurgeon, orthopedic surgeon, and pediatric surgeon.		
	6. Representative from administration.		
	7. Operating room nursing director or designee.		
	8. Emergency department nursing director or designee.		
	9. Intensive care unit nursing director or designee.		
E.	There shall be at least one of the above committee members (there must always be another representative from the trauma service in addition to the trauma medical director) at the trauma quality management committee meetings.		
F.	The trauma service shall maintain written minutes of all TQM committee meetings for at least three years. The trauma service shall have these minutes available for the Department of Health to review upon request. The minutes shall include all items specified in the standards document.		
G.	The trauma quality management committee shall prepare and submit a quarterly report to the Department of Health. The reports shall be submitted at the end of each calendar year quarter by the 15th of the month following the end of the previous quarter. The report shall:		
	1. List every case selected for corrective action by the trauma quality management committee (do not include information that would identify the patient) and shall provide the following regarding each case:		
	a. Hospital case number.		
	b. Description of questionable care.		
	c. Corrective action taken. If corrective action is not necessary, an explanation is required.		
	2. List the clinical indicators with the number of patients per quarter, number identified, and committee involvement.		
	3. List all the complications experienced by trauma patients in the quarter by number of patients and number of total patients in the quarter.		
H.	The trauma service shall maintain an in-hospital trauma registry. The minimum data set for the trauma registry shall include the items specified in the standards document.		

STANDARD XIX -- TRAUMA RESEARCH

		Yes	No
A.	The institution will have a designated trauma research director and demonstrate current involvement in and commitment to research in adult and pediatric trauma care.		

STANDARD XX -- DISASTER PLANNING AND MANAGEMENT

		Yes	No
A.	The institution will meet the disaster related requirements pursuant to s. 395.1055(1)c, F.S., and the Agency for Health Care Administration, Comprehensive Emergency Management Plan, Chapter 59A-3.078, Florida Administrative Code, and JACHO Standards.		

SECTION III

CERTIFICATION STATEMENTS

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF PREPAREDNESS AND COMMUNITY SUPPORT
TRAUMA SECTION
APPLICATION FOR LEVEL I TRAUMA CENTER

LETTER OF CERTIFICATION

I, _____, hereby certify that the information contained in this
(Name of Chief Executive Officer)
application for trauma center approval is true and accurate and represents the qualifications of

_____ as a Level I trauma center under
(Name of Hospital)
Chapter 395, F.S. I understand that once this application is submitted to the department it becomes public record and is subject to public review, and that it may become the subject of a public hearing. I further understand that the department maintains the right to inspect our hospital at any reasonable time after receipt of this application, including during provisional status, and at any time during the seven-year approval period, to ascertain the accuracy of this application and to ensure continued compliance to the standards by which this facility has been approved. It is understood that providing inaccurate or falsified information in the application subjects the hospital to the penalties in Chapter 395, F.S.

_____ _____
Date Signature of Chief Executive Officer

LEVEL I TRAUMA CENTER
SURGICAL SPECIALTIES
CERTIFICATIONS

Name of Hospital: _____

INSTRUCTIONS: The following surgical specialties must be available in-hospital, 24 hours a day for a Level I trauma center. Please confirm your hospital's compliance with the in-hospital, 24 hours a day availability requirement for the following surgical specialties by checking "Yes" or "No" next to each specialty listing or question. Reference Standard III "Surgical Services" in the standards document.

		Yes	No
A.	General or Pediatric Surgery		
1.	Is the in-hospital, 24 hours a day requirement being fulfilled by a general surgeon or pediatric surgeon who meets the requirements as defined in the trauma center standards document?		
2.	Is the in-hospital, 24 hours a day requirement being fulfilled by a senior resident in general surgery who meets the senior resident requirements as defined in the trauma center standards document?		
Comments:			

		Yes	No
B.	Neurologic Surgery		
1.	Is the in-hospital, 24 hours a day requirement being fulfilled by a neurosurgeon who also has competence in pediatric neural trauma?		
2.	Is the in-hospital, 24 hours a day requirement being fulfilled by a trauma surgeon who has special competence in the care of neural trauma including pediatric neural trauma?		
Comments:			
3.	If trauma surgeons are fulfilling this requirement, have you attached DH Form 2032-I, the statement from the Chief of Neurosurgery and trauma service medical director attesting to the competence of the in-hospital trauma surgeons to care for trauma alert patients with neural trauma including pediatric neural trauma and that they are capable of initiating measures directed toward stabilizing the trauma alert patient and pediatric trauma alert patient and initiating diagnostic procedures?		

INSTRUCTIONS: The following surgical specialties must be on call and promptly available (as defined in the standards document). The specialists on trauma call must be board certified or actively participating in the certification process with a time period set by each specialty board, in their specialty, as defined in the standards document. Please confirm your hospital's compliance with the on call and promptly available requirement of the following surgical specialties by checking "Yes" or "No" next to each specialty listing. Reference Standard III "Surgical Services" in the standards document.

		Yes	No
1.	Cardiac Surgery		
2.	Hand Surgery		
3.	Microsurgery Capabilities		
4.	Obstetric/Gynecologic Surgery		
5.	Ophthalmic Surgery		
6.	Oral/Maxillofacial Surgery		
7.	Orthopedic Surgery		
8.	Otorhinolaryngologic Surgery		
9.	Plastic Surgery		
10.	Thoracic Surgery		
11.	Urologic Surgery		

I, the undersigned chief of the department of surgery, do hereby affirm the above information is true and correct.

Name of Chief, Department of Surgery _____ Signature of Chief _____ Date _____

LEVEL I TRAUMA CENTER
NON-SURGICAL SPECIALTIES
CERTIFICATIONS

Name of Hospital: _____

INSTRUCTIONS: The following non-surgical specialties must be available in-hospital, 24 hours a day. The specialist on trauma call must be board certified or actively participating in the certification process with a time period set by each specialty board, in his or her specialty, as defined in the trauma center approval standards document. Please confirm your hospital's compliance with the in-hospital, 24 hours a day availability requirement for the following non-surgical specialties by checking "Yes" or "No" next to each specialty listing or question. The medical director for each specialty must confirm availability by signing where indicated. Reference Standard IV "Non-Surgical Services" in the standards document.

		Yes	No
1.	Emergency Medicine - The emergency medicine staff specialist is board certified or actively participating in the certification process with a time period set by each specialty board, in emergency medicine or a primary care specialty and must actively participate in emergency medicine as evidenced by his or her participation in daily emergency department routine patient care.		

Name of Emergency Department Medical Director _____ Signature of Director _____ Date _____

			Yes	No
2.	Anesthesiology			
	a.	Is the in-hospital, 24 hours a day anesthesiology requirement being fulfilled by an anesthesiologist?		
	b.	Is the in-hospital, 24 hours a day anesthesiology requirement being fulfilled by a certified registered nurse anesthetist (C.R.N.A.) or senior anesthesia resident, CA-3 or above?		
	c.	If an senior anesthesia resident or C.R.N.A. is fulfilling this requirement, is a staff anesthesiologist on call and required to be in the hospital at the time of or shortly after the trauma alert patient's arrival at the hospital or determination that surgery is needed?		

Name of Anesthesia Department Medical Director _____ Signature of Director _____ Date _____

INSTRUCTIONS: The following non-surgical specialties must be on call and promptly available (as defined in the standards document). The specialists on trauma call must be board certified or actively participating in the certification process with a time period set by each specialty board, in their specialty, as defined in the standards document. Please confirm your hospital's compliance with the on call and promptly available requirement of the following non-surgical specialties by answering "Yes" or "No" next to each specialty listing. The medical director for each specialty must confirm availability by signing where indicated. Reference Standard IV "Non-Surgical Services" in the standards document.

	Yes	No
1. Cardiology		

Name of Cardiology Department Medical Director _____ Signature of Director _____ Date _____

	Yes	No
2. Gastroenterology		

Name of Gastroenterology Dept. Medical Director _____ Signature of Director _____ Date _____

	Yes	No
3. Hematology		

Name of Hematology Department Medical Director _____ Signature of Director _____ Date _____

	Yes	No
4. Infectious Diseases		

Name of Infectious Diseases Medical Director _____ Signature of Director _____ Date _____

	Yes	No
5. Internal Medicine		

Name of Internal Medicine Medical Director _____ Signature of Director _____ Date _____

	Yes	No
6. Nephrology		

Name of Nephrology Department Medical Director | Signature of Director | Date

	Yes	No
7. Pathology		

Name of Pathology Department Medical Director | Signature of Director | Date

	Yes	No
8. Pediatrics		

Name of Pediatrics Department Medical Director | Signature of Director | Date

	Yes	No
9. Psychiatry		

Name of Psychiatry Department Medical Director | Signature of Director | Date

	Yes	No
10. Pulmonary Medicine		

Name of Pulmonology Department Medical Director | Signature of Director | Date

	Yes	No
11. Radiology - The radiology staff specialist on trauma call must have special competence in neuroradiology.		

Name of Radiology Department Medical Director | Signature of Director | Date

SECTION IV

ATTACHMENTS

Please use forms provided

LEVEL I TRAUMA CENTER
GENERAL SURGEONS COMMITMENT STATEMENT

INSTRUCTIONS: All general surgeons and surgical residents on the trauma surgery call roster must sign this statement.

I fully support my hospital's application for trauma center approval as a Level I trauma center. As a member of the general surgery trauma service staff at _____,
(Name of Hospital)
I have committed myself to the trauma surgery call roster and accordingly I agree to the following:

1. Remain in-hospital during my scheduled period of call duty and meet all trauma alert patients in the resuscitation area at the time of the trauma alert patient's arrival.

2. Perform no elective surgery or procedures, during my scheduled period of call duty, that would render me unavailable to arrive promptly (as defined in the standards document) to a trauma alert patient.

3. Refrain from taking general surgery emergency call or trauma call at any other facility while on trauma call at the primary facility.

	Typed Name of Each Trauma Surgeon	Signature of Each Trauma Surgeon	Date
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			

LEVEL I TRAUMA CENTER
GENERAL SURGEONS AVAILABLE FOR TRAUMA SURGICAL CALL

INSTRUCTIONS: The names of all general surgeons and surgical residents available for trauma surgical call must be listed with the requested information completed. All general surgeons on the trauma service must be American Board of Surgery (ABS) or American Osteopathic Board of Surgery (AOBS) certified or actively participating in the certification process with a time period set by each specialty board, or must meet the definition of alternate criteria. Reference board certified definition and Standard III.

Name of Hospital: _____ Number of General Surgeons listed below: _____

---

1. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABS or AOBS Certification _____

---

2. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABS or AOBS Certification _____

---

3. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABS or AOBS Certification _____

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4. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABS or AOBS Certification _____

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5. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABS or AOBS Certification _____

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6. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABS or AOBS Certification _____

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7. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABS or AOBS Certification _____

---

8. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABS or AOBS Certification _____

---

9. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABS or AOBS Certification _____

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10. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABS or AOBS Certification _____

---

11. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABS or AOBS Certification _____

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12. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABS or AOBS Certification _____

---

13. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABS or AOBS Certification _____

---

14. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABS or AOBS Certification _____

---

15. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABS or AOBS Certification _____

---

16. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABS or AOBS Certification _____

---

17. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABS or AOBS Certification _____

---

18. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABS or AOBS Certification _____

---

19. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABS or AOBS Certification _____

I, the undersigned trauma medical director at _____, do
(Name of Hospital)
hereby affirm the above information is true and correct and that all general surgeons available for the trauma surgical call roster are listed above. I further affirm that all of the above-listed general surgeons meet the requirements for trauma service general surgeons as provided in the standards document.

_____ _____ _____

Name of Medical Director Signature of Director Date

LEVEL I TRAUMA CENTER
NEUROSURGEONS AVAILABLE FOR TRAUMA SURGICAL CALL

INSTRUCTIONS: The names of all neurosurgeons available for trauma surgical call must be listed with the requested information completed. All neurosurgeons on the trauma service must be American Board of Neurological Surgery (ABNS) or American Osteopathic Board of Surgery-Neurological (AOBS-N) certified, or actively participating in the certification process with a time period set by each specialty board, or must meet the definition of alternate criteria. Reference board certified definition and Standard III.

Name of Hospital: _____ Number of Neurosurgeons listed below: _____

---

1. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABNS or AOBS-N Certification _____

---

2. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABNS or AOBS-N Certification _____

---

3. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABNS or AOBS-N Certification _____

---

4. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABNS or AOBS-N Certification _____

---

5. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABNS or AOBS-N Certification _____

---

6. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABNS or AOBS-N Certification _____

---

7. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABNS or AOBS-N Certification _____

I, the undersigned Chief of Neurosurgery at _____,
(Name of Hospital)
do hereby affirm the above information is true and correct and that all neurosurgeons available for the trauma surgical call roster are listed above. I further affirm that all of the above-listed neurosurgeons meet the requirements for trauma service neurosurgeons as provided in the standards document.

_____ _____ _____

Name of Chief of Neurosurgery Signature of Director Date

LEVEL I TRAUMA CENTER
NEUROLOGICAL, PEDIATRIC, AND NEURORADIOLOGY STATEMENTS

I, _____, and I, _____,
(Name of Chief of Neurosurgery) (Name of Trauma Medical Director)
at _____ have judged the surgeons or physicians responsible for trauma
(Name of Hospital)
care to have special competence in the care of trauma alert patients with neural trauma. These trauma surgeons or physicians are capable of initiating measures directed toward stabilizing the trauma alert patient and initiating diagnostic procedures as provided in the trauma center approval standards.

_____ _____
Signature of Chief of Neurosurgery Signature of Trauma Medical Director

_____ _____
Date Date

PEDIATRIC TRAUMA AND NEUROLOGICAL STATEMENT

I, _____, and I, _____,
(Name of Chief of Neurosurgery) (Name of Trauma Medical Director)
at _____ have judged the surgeons or physicians responsible for pediatric
(Name of Hospital)
trauma care to have special competence in the care of pediatric trauma alert patients including those with neural trauma. These trauma surgeons or physicians are capable of initiating measures directed toward stabilizing the pediatric trauma alert patient and initiating diagnostic procedures as provided in the trauma center approval standards.

_____ _____
Signature of Chief of Neurosurgery Signature of Trauma Medical Director

_____ _____
Date Date

NEURORADIOLOGY STATEMENT

I, _____, and I, _____,
(Name of Chief of Neurosurgery) (Name of Trauma Medical Director)
at _____ have judged the radiologists responsible for trauma care to have
(Name of Hospital)
special competence in neuroradiology.

_____ _____
Signature of Chief of Neurosurgery Signature of Trauma Medical Director

_____ _____
Date Date

LEVEL I TRAUMA CENTER
SURGICAL SPECIALISTS ON CALL AND PROMPTLY AVAILABLE

INSTRUCTIONS: The names of all surgeons, by specialty, on call and promptly available (as defined in the standards document) for the trauma service must be listed with the requested information completed. All surgeons must be board certified or actively participating in the certification process with a time period set by each specialty board in their specialty. Reference board certified definition and Standard III. All surgical specialties listed are required for Level I trauma centers.

Name of Hospital: _____ Surgical Specialty: CARDIAC

1. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

2. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

3. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

Name of Hospital: _____ Surgical Specialty: CARDIAC (Continued)

4. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

5. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

6. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

PLEASE USE ADDITIONAL SHEETS IF NECESSARY

Name of Hospital: _____ Surgical Specialty: GYNECOLOGIC

1. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

2. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

3. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

Name of Hospital: _____ Surgical Specialty: GYNECOLOGIC (Cont.)

4. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

5. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

6. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

PLEASE USE ADDITIONAL SHEETS IF NECESSARY

Name of Hospital: _____ Surgical Specialty: HAND

1. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

2. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

3. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

Name of Hospital: _____ Surgical Specialty: HAND (Continued)

4. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

5. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

6. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

PLEASE USE ADDITIONAL SHEETS IF NECESSARY

Name of Hospital: _____ Surgical Specialty: MICROSURGERY CAPABILITIES

1. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

2. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

3. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

Name of Hospital: _____ Surgical Specialty: MICROSURGERY CAPABILITIES (Continued)

4. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

5. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

6. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

PLEASE USE ADDITIONAL SHEETS IF NECESSARY

Name of Hospital: _____ Surgical Specialty: OPTHALMIC

1. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

2. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

3. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

Name of Hospital: _____ Surgical Specialty: OPTHAMLIC (Continued)

4. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

5. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

6. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

PLEASE USE ADDITIONAL SHEETS IF NECESSARY

Name of Hospital: _____ Surgical Specialty: ORAL/MAXILLOFACIAL

1. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

2. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

3. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

Name of Hospital: _____ Surgical Specialty: ORAL/MAXILLOFACIAL (Continued)

4. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

5. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

6. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

PLEASE USE ADDITIONAL SHEETS IF NECESSARY

Name of Hospital: _____ Surgical Specialty: ORTHOPEDIC

1. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

2. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

3. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

Name of Hospital: _____ Surgical Specialty: ORTHOPEDIC (Continued)

4. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

5. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

6. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

PLEASE USE ADDITIONAL SHEETS IF NECESSARY

Name of Hospital: _____ Surgical Specialty: OTORHINOLARYNGOLOGIC

1. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

2. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

3. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

Name of Hospital: _____ Surgical Specialty: OTORHINOLARYNGOLOGIC (Continued)

4. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

5. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

6. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

PLEASE USE ADDITIONAL SHEETS IF NECESSARY

Name of Hospital: _____ Surgical Specialty: PEDIATRIC

1. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

2. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

3. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

Name of Hospital: _____ Surgical Specialty: PEDIATRIC (Continued)

4. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

5. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

6. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

PLEASE USE ADDITIONAL SHEETS IF NECESSARY

Name of Hospital: _____ Surgical Specialty: PLASTIC

1. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

2. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

3. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

Name of Hospital: _____ Surgical Specialty: PLASTIC (Continued)

4. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

5. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

6. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

PLEASE USE ADDITIONAL SHEETS IF NECESSARY

Name of Hospital: _____ Surgical Specialty: THORACIC

1. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

2. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

3. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

Name of Hospital: _____ Surgical Specialty: THORACIC (Continued)

4. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

5. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

6. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

PLEASE USE ADDITIONAL SHEETS IF NECESSARY

Name of Hospital: _____ Surgical Specialty: UROLOGIC

1. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

2. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

3. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

Name of Hospital: _____ Surgical Specialty: UROLOGIC (Continued)

4. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

5. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

6. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

PLEASE USE ADDITIONAL SHEETS IF NECESSARY

LEVEL I TRAUMA CENTER
EMERGENCY DEPARTMENT PHYSICIANS

INSTRUCTIONS: The names of all emergency physicians on duty in the emergency department must be listed with the requested information completed. All emergency physicians must be board certified or actively participating in the certification process with a time period set by each specialty board in emergency medicine or a primary care specialty, or must meet the definition of alternate criteria. Reference board certified definition and Standard V. All emergency department medical directors shall be board certified by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM). All emergency medicine physicians must be board certified or actively participating in the certification process with a time period set by each specialty board by the ABEM or AOBEM, or must meet the definition of alternate criteria. Reference board certified and definition in the standards document.

Name of Hospital _____ Number of Emergency Physicians listed below _____

---

1. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____ Current ACLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABEM or AOBEM Certification _____

---

2. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____ Current ACLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABEM or AOBEM Certification _____

---

3. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____ Current ACLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABEM or AOBEM Certification _____

---

4. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____ Current ACLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABEM or AOBEM Certification _____

---

5. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____ Current ACLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABEM or AOBEM Certification _____

---

6. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____ Current ACLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABEM or AOBEM Certification _____

---

7. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____ Current ACLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABEM or AOBEM Certification _____

---

8. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____ Current ACLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABEM or AOBEM Certification _____

---

9. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____ Current ACLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABEM or AOBEM Certification _____

---

10. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____ Current ACLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABEM or AOBEM Certification _____

---

11. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____ Current ACLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABEM or AOBEM Certification _____

---

12. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____ Current ACLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABEM or AOBEM Certification _____

---

13. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____ Current ACLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABEM or AOBEM Certification _____

---

14. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____ Current ACLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABEM or AOBEM Certification _____

---

15. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____ Current ACLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABEM or AOBEM Certification _____

---

16. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____ Current ACLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABEM or AOBEM Certification _____

---

17. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____ Current ACLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABEM or AOBEM Certification _____

---

18. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____ Current ACLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABEM or AOBEM Certification _____

---

19. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____ Current ACLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABEM or AOBEM Certification _____

I, the undersigned emergency department medical director at _____,
(Name of Hospital)
do hereby affirm the above information is true and correct and that all emergency physicians available for the emergency department are listed above. I further affirm that all of the above-listed emergency physicians meet the requirements for trauma center emergency department physicians as provided in the standards document.

_____ _____ _____

Name of Medical Director Signature of Director Date

LEVEL I TRAUMA CENTER
ANESTHESIOLOGISTS AVAILABLE FOR TRAUMA CALL

INSTRUCTIONS: The names of all anesthesiologists and anesthesiology residents available for trauma surgical call must be listed with the requested information completed. All anesthesiologists on the trauma service must be American Board of Anesthesiology (ABA) or American Osteopathic Board of Anesthesiology (AOBA) certified or actively participating in the certification process with a time period set by each specialty board. Reference board certified definition and Standard IV.

Name of Hospital: _____ Number of Anesthesiologists listed below: _____

1. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____ Current ACLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABA or AOBA Certification _____

---

2. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____ Current ACLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABA or AOBA Certification _____

---

3. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____ Current ACLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABA or AOBA Certification _____

---

4. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____ Current ACLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABA or AOBA Certification _____

---

5. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____ Current ACLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABA or AOBA Certification _____

---

6. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____ Current ACLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABA or AOBA Certification _____

---

7. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

Current ATLS Completion Date _____ Current ACLS Completion Date _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date of ABA or AOBA Certification _____

I, the undersigned Chief of Anesthesiology at _____,
(Name of Hospital)
do hereby affirm the above information is true and correct and that all anesthesiologists available for the trauma surgical call roster are listed above. I further affirm that all of the above-listed anesthesiologists meet the requirements for trauma service anesthesiologists as provided in the standards document.

_____ _____ _____

Name of Chief of Anesthesiology Signature of Chief Date

LEVEL I TRAUMA CENTER
CERTIFIED REGISTERED NURSE ANESTHETISTS (C.R.N.A.s)
AVAILABLE FOR TRAUMA CALL

INSTRUCTIONS: Please list the names of all C.R.N.A.s fulfilling the in-hospital, 24 hours a day anesthesiology requirement for Level I trauma centers. Reference Standard IV "Non-Surgical Services" in the standards document.

Typed Name of Each C.R.N.A.

1 _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____

LEVEL I TRAUMA CENTER
NON-SURGICAL SPECIALISTS ON CALL AND PROMPTLY AVAILABLE

INSTRUCTIONS: The names of all non-surgical specialists, by specialty, shall be available 24 hours a day to arrive promptly at the trauma center when summoned (as defined in the standards document) for the trauma service must be listed. All specialists shall be board certified or actively participating in the certification process with a time period set by each specialty board in their respective specialties, and granted medical staff privileges by the hospital to care for adult and pediatric patients. All non-surgical specialties listed are required for Level I trauma centers.

Name of Hospital: _____ Non-Surgical Specialty: CARDIOLOGY

1. Name _____ Address _____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

2. Name _____ Address _____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

3. Name _____ Address _____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

Name of Hospital: _____ Non-Surgical Specialty: _____

4. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location – City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

5. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location – City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

6. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location – City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

PLEASE USE ADDITIONAL SHEETS IF NECESSARY

GASTROENTEROLOGY

Name of Hospital: _____ Non-Surgical Specialty: _____

1. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

2. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

3. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

Name of Hospital: _____ Non-Surgical Specialty: GASTROENTEROLOGY (continues)

4. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location – City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

5. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location – City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

6. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location – City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

PLEASE USE ADDITIONAL SHEETS IF NECESSARY

Name of Hospital: _____ Non-Surgical Specialty: HEMATOLOGY

1. Name _____ Address _____

Name of Medical School _____ Date Completed _____

Location – City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

2. Name _____ Address _____

Name of Medical School _____ Date Completed _____

Location – City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

3. Name _____ Address _____

Name of Medical School _____ Date Completed _____

Location – City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

4. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

5. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

6. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

PLEASE USE ADDITIONAL SHEETS IF NECESSARY

Name of Hospital: _____

Non-Surgical Specialty: INFECTIOUS DISEASE

1. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location – City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

2. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location – City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

3. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location – City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

Name of Hospital: _____

Non-Surgical Specialty: INFECTIOUS DISEASE (Continues)

4. Name _____ Address _____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

5. Name _____ Address _____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

6. Name _____ Address _____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

PLEASE USE ADDITIONAL SHEETS IF NECESSARY

Name of Hospital: _____

INTERNAL MEDICINE

Non-Surgical Specialty: _____

1. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location – City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

2. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location – City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

3. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location – City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

Name of Hospital: _____

Non-Surgical Specialty: _____

INTERNAL MEDICINE (Continues)

4. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

5. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

6. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

PLEASE USE ADDITIONAL SHEETS IF NECESSARY

Name of Hospital: _____ Non-Surgical Specialty: NEPHROLOGY

1. Name _____ Address _____

Name of Medical School _____ Date Completed _____

Location – City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

2. Name _____ Address _____

Name of Medical School _____ Date Completed _____

Location – City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

3. Name _____ Address _____

Name of Medical School _____ Date Completed _____

Location – City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

Name of Hospital: _____ Non-Surgical Specialty: _____

NEPHROLOGY (Continues)

4. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

5. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

6. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

PLEASE USE ADDITIONAL SHEETS IF NECESSARY

Name of Hospital: _____ Non-Surgical Specialty: PATHOLOGY _____

1. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location – City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

2. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location – City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

3. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location – City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

Name of Hospital: _____ Non-Surgical Specialty: _____

PATHOLOGY (Continues)

4. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

---

5. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

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6. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

PLEASE USE ADDITIONAL SHEETS IF NECESSARY

Name of Hospital: _____ Non-Surgical Specialty: PEDIATRICS _____

1. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location – City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

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2. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location – City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

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3. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location – City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

Name of Hospital: _____ Non-Surgical Specialty: _____

PEDIATRICS (Continues)

4. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

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5. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

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6. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

PLEASE USE ADDITIONAL SHEETS IF NECESSARY

Name of Hospital: _____ Non-Surgical Specialty: PSYCHIATRY

1. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location – City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

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2. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location – City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

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3. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location – City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

Name of Hospital: _____ Non-Surgical Specialty: _____

PSYCHIATRY (Continues)

4. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

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5. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

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6. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

PLEASE USE ADDITIONAL SHEETS IF NECESSARY

Name of Hospital: _____ Non-Surgical Specialty: PULMONARY MEDICINE

1. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location – City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

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2. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location – City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

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3. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location – City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

Name of Hospital: _____

Non-Surgical Specialty: PULMONARY MEDICINE (Continues)

4. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

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5. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

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6. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

PLEASE USE ADDITIONAL SHEETS IF NECESSARY

Name of Hospital: _____ Non-Surgical Specialty: RADIOLOGY _____

1. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location – City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

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2. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location – City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

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3. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location – City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

Name of Hospital: _____ Non-Surgical Specialty: _____

RADIOLOGY (Continues)

4. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

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5. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

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6. Name _____ Address _____

_____

Name of Medical School _____ Date Completed _____

Location - City, State _____

ACGME or AOA Approved Residency Location _____ Date Successfully Completed _____

Specialty Area of Residency _____

Florida Physician License # _____ Expiration Date _____

Date ABS or AOBS Certification _____

PLEASE USE ADDITIONAL SHEETS IF NECESSARY

SECTION V

ATTACHMENTS

Please provide the information requested in Section V of the introduction portion of this manual. Please type and use 8 1/2 X 11 paper for all Section V attachments.