Division of Emergency Preparedness & Community Support
Bureau of Emergency Medical Oversight
Trauma Section

TRAUMA CENTER APPLICATION TO RENEW

SECTION I: TYPE OF APPLICATION

Check the appropriate category(s) of Trauma Center being renewed:

_____Level I Trauma Center *(includes Pediatric Trauma Center)*

_____Level II Trauma Center

_____Pediatric Trauma Center

SECTION II: GENERAL INFORMATION

A. Name of Hospital_____
Street Address_____
City, State, Zip Code_____
Mailing Address_____
City, State, Zip Code_____

B. Chief Executive Officer_____
Telephone Number_____Fax Number_____
Email Address: _____

C. Contact Person for Application_____
Telephone Number_____Fax Number_____
Email Address: _____

D. Trauma Medical Director_____
Telephone Number_____Fax Number_____
Email Address: _____

E. Trauma Program Manager_____
Telephone Number_____Fax Number_____
Email Address: _____

SECTION III: RENEWAL CERTIFICATION

We, the undersigned, hereby certify that _____ complies with all

(Hospital Name)

of Chapter 395, Part II, Florida Statutes; Rule 64J-2, Florida Administrative Code; and the trauma center standards published in DHP 150-9, January 2010, "Trauma Center Standards," for the category(ies) of trauma centers listed in Section I. We also certify that the hospital has a current and complete trauma center application available at the facility for review by the department. We further understand that the department may conduct a site survey of our hospital at any reasonable time during the seven-year approval period. It is understood that providing inaccurate or falsified information in the renewal application subjects our hospital to the penalties in Chapter 395, Florida Statutes, and as further provided by law. We further understand that this form must be executed completely and returned to the department within fifteen calendar days of receipt in order to be considered by the department.

(Print Name)	*(Signature of Chief Executive Officer)* *(Date)*
(Print Name)	*(Signature of Trauma Medical Director)* *(Date)*
(Print Name)	*(Signature of Trauma Program Manager* *(Date)*