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)*