APPLICATION FOR INITIAL/RENEWAL DESIGNATION AS AN
EMS PEDIATRIC DESTINATION HOSPITAL

Name of Institution:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Telephone:_____ FAX:_____ E-Mail:_____

Owner of Facility:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Telephone:_____ FAX:_____ E-Mail:_____

Hospital Administrator/Director:_____

Contact Person for Application Processing:_____

Telephone:_____ FAX:_____ E-Mail:_____

To be a pediatric destination facility, the hospital must be in compliance with the following conditions. Do you attest to the fact your facility:

1. Provides 24/7 in-house coverage for the Emergency Room with one of the following:
    a. A Board Certified (BC) or Board Eligible (BE) pediatric emergency medicine physician
    b. A BC/BE emergency medicine physician
    c. A BC/BE general pediatrician, at the discretion of the pediatric Medical Director of the facility.

    Yes No

2. Has a Pediatric Intensive Care Unit that provides 24/7 coverage with a BC/BE pediatric critical care specialist (PCC) available on site within 30 minutes by contract:

    Yes No

3. Provides nursing services; 80% of pediatric ED nurses must have Emergency Nursing Pediatric Course (ENPC) certification with at least one ENPC nurse present at all times:

    Yes No

4. Has ED nurses who possess a current Pediatric Advanced Life Support (PALS) card:

    Yes No

5. Has a medical director who is BC/BE in pediatric emergency medicine:

   Yes No

6. Provides Quality improvement activities conducted by the medical director or PCC physician or their designee:

   Yes No

I have read and completed the application to the best of my ability and attest to the fact the information provided is true and complete to the best of my knowledge.

I authorize the release of such information as may pertain to the purpose of this application.

I understand any misstatements or omissions of material facts may cause forfeiture of the right to participate as an EMS Pediatric Destination Hospital.

I understand and agree to comply with the conditions set forth in the application.

Signature of Hospital Chief Executive Officer: _____Date:_____

Printed Name of Hospital Administrator or Owner: _____

Title of Person signing the Application: _____