SNHD
Southern Nevada Health District

APPLICATION FOR RENEWAL OF AUTHORIZATION AS A CENTER FOR THE TREATMENT OF TRAUMA

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:_____

Level of Center for the Treatment of Trauma renewal being sought:

☐ Level I ☐ Level II ☐ Level III
☐ Pediatric Level I ☐ Pediatric Level II

Date of original designation:_____

Date of last renewal of designation:_____

Briefly describe any changes in the hospital's capacity to provide trauma services in the community during the past designation period:

_____
_____
_____
_____
_____
_____

Briefly describe any changes in the hospital's capabilities to provide trauma services in the community during the past designation period:

_____
_____
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_____
_____
_____

Briefly describe any changes in the hospital's longitudinal commitment (expected to be greater than five years) to provide trauma services in the community during the past designation period:

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_____

Additional information the applicant would like to provide in support of their request:

_____
_____
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_____
_____
_____

Has the applicant been in compliance with the conditions for authorization as a center for the treatment of trauma as outlined below during this past designation period?

1. Submitted trauma data to SNHD and the State Trauma Registry.

   □ Yes □ No

2. Actively participated in the Regional Trauma Advisory Board and Trauma System Performance Improvement activities.

   □ Yes □ No

3. Complied with all applicable SNHD regulations and State Health Division requirements for authorized and designated centers for the treatment of trauma.

   □ 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 authorization as a center for the treatment of trauma.

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

Signature of Hospital Administrator or Owner_____Date:_____

Printed Name of Hospital Administrator or Owner:_____

Title of Person signing the Application:_____