Trauma Center Designation
Application

Date of Application: _____

☐ Initial ☐ Designation Renewal, current expiration date: Month ____ / Day ____/Year ____

☐ Level I ☐ Level II ☐ Level III ☐ Level IV

Facility Name			
Physical Address (No PO Box)	Street		
	City		Zip
Main Phone		***ED Phone***	
Facility Website			
Level I, II, III	☐ 1 year ACS verification ☐ 3 year ACS verification **Copy of ACS verification certificate must accompany this application*		

Trauma Medical Director (TMD)	
Name	Credentials
Phone	Cell
Email	

Trauma Program Manager/Coordinator (TPM)	
Name	Credentials
Phone	Cell
Email	

Director of Nursing (DON)	
Name	Credentials
Phone	Cell
Email	

President/ Chief Executive Officer/ Hospital Administrator	
Name	Credentials
Phone	Cell
Email	

I attest to the validity of the content of this application and confirm our hospital's readiness to proceed with the designation process.

☐ Agree ☐ Disagree

Signature: _____ Date: _____

President / Chief Executive Officer / Hospital Administrator

Fee: Level I, II, III $500.00 Level IV $250.00

For check payment, Issue/submit to:
Kansas Dept. of Health & Environment
Kansas Trauma Program
ATTN: Regional Trauma Coordinator
1000 SW Jackson, Suite 340
Topeka, KS 66612-1365

For credit card payment:
Contact Wendy O'Hare, (785) 296-1210