KANSAS TRAUMA PROGRAM

STATE OF KANSAS
DEPARTMENT OF HEALTH AND ENVIRONMENT
DIVISION OF HEALTH
Office of Local and Rural Health

TRAUMA CARE FACILITY DESIGNATION APPLICATION

Please complete all of the following sections:

Section 1 - Contact Information

Date of application: _____

Name of Facility applying for certificate: _____

Please list name and contact information for the individual we may contact for any questions regarding this application.

Name: _____

Title: _____

Phone: _____

E-mail: _____

Section 2 - Please check the type of application:

◯ **New** ◯ **Renewal** ◯ **Reclassification**

Section 3 - Please check level of designation for which you are applying:

◯ **Level I Trauma Center** ◯ **Level II Trauma Center** ◯ **Level III Trauma Center**

Section 4 - Please choose one of the following options:

Option 1

☐ We are requesting to schedule an on-site survey for our facility. KDHE will contact your facility to schedule the on-site survey.

Please provide the name and contact information of the individual we may contact to schedule the on-site survey.

Contact Person: _____

Contact Phone: _____

Contact E-mail: _____

OR:

Option 2

☐ We have enclosed a copy of our ACS verification certificate.

◯ 1 year ACS certificate of verification ◯ 3 year ACS certificate of verification

Section 5 - Application Fee

☐ **Enclosed is a nonrefundable application fee of $500.00**

Section 6 - Name of Facility as you wish it listed on certificate and for public information purposes: _____

Section 7 - Acknowledgement and Signature:

Applications are not complete until all supporting documents are received by KDHE. KDHE will notify applicants within 30 days after receiving a completed application. (K.A.R. 28-54-3)

Applicant requesting an on-site survey review will be responsible for a nonrefundable fee which will be due 30 days before the scheduled on-site survey. (K.A.R. 28-54-3)

If an applicant no longer wishes to maintain their certificate of designation, they will provide 60 days advanced notice to KDHE along with a plan for notifying medical providers in their trauma region. (K.A.R. 28-54-6)

Signature: _____ Date: _____