MDHHS
Michigan Department of Health & Human Services

Request for In-State Verification Site Review, Level III Trauma Facility

This packet contains instructions and forms required to submit a request to the Michigan Department of Health and Human Services to conduct a site review to be designated as a Michigan Trauma Facility.

Introduction

This form should be utilized by those facilities requesting a site visit to verify they meet the requirements set out in the Michigan Trauma Rules. This step is required before a facility can be designated as a Michigan trauma facility. Use these instructions for filling out the single page *Request for In-State Trauma Facility Verification Site Review Level III* form.

Applicants must have 12 months of operations as a functional trauma facility prior to a site visit. This includes the collection and submission of data, performance improvement, injury prevention, and all other required activities. ***Submission of this form indicates the facility has developed their trauma program and will be ready for a site review in at least 90 days.***

Please note, at the top of the form, date of request should be the date the form is submitted to the Michigan Department of Health and Human Services (MDHHS).

Facilities that are currently verified by the American College of Surgeons (ACS) should not use this form.

Submission of Request

The request form must be filled out completely and **signed** by the healthcare facility's Chief Executive Officer and Trauma Medical Director. Please complete each section of the form. Incomplete forms will be returned. The request for verification can be submitted electronically. **Note**, put "Request for Verification" in the subject line and email to:

traumadesignationcoordinator@michigan.gov

Alternatively, a hard copy of the request for verification can be mailed to:

Michigan Department of Health and Human Services
EMS and Trauma Division
Attn: Trauma Designation Coordinator
PO Box 30207
Lansing, MI 48909

Once the request is received by the State Trauma Designation Coordinator, the contact person listed in the application will receive electronic confirmation of receipt.

Consistent with applicable law, MDHHS will exercise its discretion to exempt from public disclosure trade secret, commercial, or financial information provided voluntarily to it as part of the Level III In-State Trauma Facility Designation process, as permitted under Section 13(1) of the Michigan Freedom of Information Act, MCL § 15.231 *et. seq*.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
EMS AND TRAUMA DIVISION

Request for In-State Trauma Facility Verification Site Review Level III

This form should be utilized for heathcare facilites seeking **In-state** verfication as a Level III trauma facility

In accordance with the requirements of the Michigan Department of Health and Human Services, EMS and Trauma Services Section Statewide Trauma Plan (By authority conferred on the department of community health by sections 9227 and 20910 of 1978 PA 368, MCL 333.9227 and 333.20910; 2004 PA 580, 2004 PA 581, 2004 PA 582 and executive Reorganization Order Nos.1996-1 and 2003-1, MCL 333.2097a, 333.20908, 333.10910, 330.3101 and 445.2011.)	**Level III Site Review:** Date of Request: _____/_____/_____ Date Of Site Review (MDHHS Use Only)

HOSPITAL INFORMATION

Name of Hospital:	
Address:	

STAFF INFORMATION - Please use names as they appear on official correspondence and business contact information.

Chief Executive Officer (Name and Title)	Trauma Medical Director (Name and Title)
Email Address	Email Address
Phone	Phone
Trauma Program Manager/Nurse Coordinator (Name and Title)	Physician Director of Emergency Medicine (Name and Title)
Email Address	Email Address
Phone	Phone
Contact Person (if different from TPM/TNC)	Trauma Registrar (Name and Title)
Email Address	Email Address
Phone	Phone

____ ***Check here if the trauma facility is currently in the American College of Surgeons verification process.***

This requst for in-state verification site review must be completed and signed by the organization's leadership.

Hospital CEO Name	
Hospital CEO Signature	
Date of signature	

Trauma Medical Director	
Signature	
Date of signature	

Completion of this request confirms the following is in place: 12 months of data functioning as a trauma facility, performance improvement activities, and activities in regional injury prevention.

Send this completed form to: traumadesignationcoordinator@michigan.gov
Or mail to: MDHHS Trauma Verification/Designation Coordinator, PO Box 30207, Lansing, MI 48909
Upon reciept of this completed form the contact person will receive electronic confirmation.

Consistent with applicable law, MDHHS will exercise its discretion to exempt from public disclosure trade secret, commercial, or financial information provided voluntarily to it as part of the Level III In-State Trauma Facility Designation process, as permitted under Section 13(1) of the Michigan Freedom of Information Act, MCL § 15.231 *et. seq* .