



State of Florida  
Department of Health  
Office of Trauma



TRAUMA CENTER APPLICATION TO RENEW

SECTION I: TYPE OF APPLICATION

Check the appropriate category(s) of Trauma Center being renewed:

\_\_\_\_\_ Level I Trauma Center (*includes Pediatric Trauma Center*)

\_\_\_\_\_ Level II Trauma Center

\_\_\_\_\_ Pediatric Trauma Center

SECTION II: GENERAL INFORMATION

A. Name of Hospital \_\_\_\_\_  
Street Address \_\_\_\_\_  
City, State, Zip Code \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
City, State, Zip Code \_\_\_\_\_

B. Chief Executive Officer \_\_\_\_\_  
Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

C. Contact Person for Application \_\_\_\_\_  
Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

D. Trauma Medical Director \_\_\_\_\_  
Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

E. Trauma Program Manager \_\_\_\_\_  
Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

**SECTION III: RENEWAL CERTIFICATION**

We, the undersigned, hereby certify that \_\_\_\_\_ complies with all  
*(Hospital Name)*

of Chapter 395, Part II, Florida Statutes; Rule 64J-2, Florida Administrative Code; and the trauma center standards published in DHP 150-9, January 2008, "Trauma Center Standards," for the category(ies) of trauma centers listed in Section I. We also certify that the hospital has a current and complete trauma center application available at the facility for review by the department. We further understand that the department may conduct a site survey of our hospital at any reasonable time during the seven-year approval period. It is understood that providing inaccurate or falsified information in the renewal application subjects our hospital to the penalties in Chapter 395, Florida Statutes, and as further provided by law. We further understand that this form must be executed completely and returned to the department within fifteen calendar days of receipt in order to be considered by the department.

\_\_\_\_\_  
*(Print Name)*

\_\_\_\_\_  
*(Signature of Chief Executive Officer) (date)*

\_\_\_\_\_  
*(Print Name)*

\_\_\_\_\_  
*(Signature of Trauma Medical Director) (date)*

\_\_\_\_\_  
*(Print Name)*

\_\_\_\_\_  
*(Signature of Trauma Program Manager) (date)*