**HOSPITAL NAME AND ADDRESS**

**ADMINISTRATION INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Name** | **E-mail** | **Phone Number** |
| Chief Executive Officer |  |  |  |
| Chief Nursing Officer  |  |  |  |
| ED Medical Director |  |  |  |
| EDAP Medical Director |  |  |  |
| Designated Pediatric Consultant |  |  |  |
| ED Clinical Director |  |  |  |
| ED Manager |  |  |  |
| Pediatric Liaison Nurse |  |  |  |
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**PEDIATRIC PATIENT INFORMATION**

**Pediatric Patients are admitted to an in-patient unit at this facility?  YES  NO**

**Total Emergency Department Pediatric Patient Volume for prior 3 years:**

 **Volume \_\_\_\_\_ Year \_\_\_\_\_\_**

 **Volume \_\_\_\_\_ Year \_\_\_\_\_\_**

 **Volume \_\_\_\_\_ Year \_\_\_\_\_\_**

**EMERGENCY DEPARTMENT PHYSICIANS:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **NAME** | **ABMS****Specialty****EM** **or** **PEM** | **ABMS Board Certification Profile to validate BC** **“End Date” or Re-verification Date”** | **EM Board Eligibility (BE)** **Time frame:** **Date MD is eligible to sit for the Boards****(if applicable)** | **Hours Worked****for** **one month** |
|  **EDAP Medical Director** |  |  |  |  |
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**PEDIATRICIANS (applies to EDAPs with associated pediatric admission unit)**

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| **NAME** | **ABMS or AAP****General Pediatrics** | **ABMS Board Certification Profile to validate BC** **“End Date” or Re-verification Date”** | **YES** **Call Panel****Physicians****(Only)** |
| **Designated Pediatric Consultant** |  |  |  |
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**PEDIATRIC SUBSPECIALTY SERVICES**

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| --- | --- | --- | --- | --- | --- |
| **NAME** | **ABMS** **Subspecialty****(Ped Intensivist, Ped Cardiology. Ped Surgery, etc.)** | **ABMS Board Certification Profile to validate BC** **“End Date” or Re-verification Date”** | **Telehealth****Y/N****Provide Agreement** | **Transfer Agreement** **Y/N****Provide** **Agreements** | **YES****Call** **Panel Physicians****(Only)** |
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**DIAGNOSTIC RADIOLOGIST**

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| --- | --- | --- | --- |
| **NAME** | **ABMS****Diagnostic****Radiologist** | **ABMS Board Certification Profile to validate BC****“End Date” or Re-verification Date”** |  **YES** **Call Panel****Physicians****(Only)** |
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**ADVANCED PRACTICE PROVIDERS (Physician Assistants and Nurse Practitioners)**

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| **NAME** | **PA / NP** | **PALS** **Renew by****Or** **Recertification** **Date** |
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**RESPIRATORY CARE PRACTITIONERS (RCP)**

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| **NAME** | **PALS** **Renew by****Or** **Recertification** **Date** |
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