**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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