

**Kentucky EMS for Children Program (KYEMSC)
Kentucky Pediatric Emergency Care Coalition (KPECC)**

Hospital Application for
Emergency Department Pediatric Readiness Recognition

Initial Verification/Recognition

Re-Verification/Recognition

Name of Facility

City

County

Application Date

Site Visit Dates for Initial or Re-Verification
(Looking at least 8 weeks out from the application date.)

Suggested Dates: (1) _____
(2) _____
(3) _____
(4) _____

To submit via post, mail to:
KY Board of EMS
KYEMSC Project Director
118 James Court, Ste 50
Lexington, KY 40505
859-256-3583

To submit electronically, email to
morgan.scaggs@kctcs.edu

Instructions

The complete application package consists of:

1. Application, completed and signed
2. A copy of the completed Pre-Review Questionnaire (PRQ)
3. Payment of the application fee with an official hospital check in the amount of \$500.

(There are no additional site visit fees. This fee is waived entirely for officially designated Critical Access Hospitals)

Note that some questions will need to be answered on the PRQ,
and some materials will need to be assembled and available for review during the site visit.

The KPECC Pediatric Ready ED Recognition Criteria, available on the Kentucky Board of EMS website at <https://kbems.kctcs.edu/emsc/kpecc/resources.aspx> is listed as a reference for completing this application and verification process.

Contact the KYEMSC Project Director at KBEMS listed on the title page of this document for assistance or if you have questions while completing the application.

When you have completed the application:

- Print a hard copy of the completed pdf to obtain signatures;
- Make a copy of the application and attachments for your records;
- Enclose an official hospital check in the amount of \$500 (unless CAH);
Check here if your facility is an officially designated Critical Access Hospital.
- Mail the application package to:

Mail application package and/or payment to:

KY Board of EMS
ATTN: KYEMSC Project Director
118 James Court, Ste 50
Lexington, KY 40505

Upon receipt of your application and fee, the package will be reviewed for completeness. The KYEMSC Project Director will then schedule a site visit to assess if the essential criteria have been met. The KPECC Steering Committee and the KYEMSC Advisory Committee will review the site team's findings and if appropriate will issue formal recognition.

If the Committee determines that deficiencies in meeting the criteria exist, you will be contacted in writing and provided with a detailed description of how to remedy the deficiencies along with a time line to do so.

KEY HOSPITAL PERSONNEL

List Name, Title, and other information as noted below.

Chief Executive Officer: _____

Title: _____

Contact Number: _____

Name of the Nursing Pediatric Emergency Care Coordinator: _____

Title: _____

Primary Contact Number: _____

Email: _____

Name of the Physician Pediatric Emergency Care Coordinator: _____

Title: _____

Primary Contact Number: _____

Email: _____

Name of Emergency Department Manager: _____

Title: _____

Primary Contact Number: _____

Email: _____

Name of Pre-hospital Coordinator or Liaison: _____

Title: _____

Primary Contact Number: _____

Email: _____

KEY HOSPITAL PERSONNEL CONTINUED

Trauma Coordinator (if applicable): _____

Title: _____

Primary Contact Number: _____

Email: _____

Emergency Preparedness Coordinator: _____

Title: _____

Primary Contact Number: _____

Email: _____

Any Additional Personnel or Information You Wish to Include:

KEY PARTNER INFORMATION

List Name, Title, and other information as noted below.

Lead 911 EMS Agency: _____

Contact Person: _____

Title: _____

Primary Contact Number: _____

After-hours Contact Number: _____

Email: _____

EMS Agency Pediatric Emergency Care Coordinator: _____

Primary Contact Number: _____

After-hours Contact Number: _____

Email: _____

Lead Air Medical Transport Provider: _____

Contact Person: _____

Title: _____

Primary Contact Number: _____

Email: _____

Air Medical Dispatch Number: _____

Location of air medical base: _____

Response time from air medical base to facility: _____

List the name of **Hospitals** you have transferred pediatric patients to in the previous 12 months:

Signature Page

I hereby make application on behalf of this hospital for verification and recognition as a Pediatric Ready Emergency Department in the Commonwealth of Kentucky.

I certify that:

- I have read and understand all of the criteria requirements of the Kentucky Pediatric Readiness Program, and this hospital meets or exceeds the criteria as set forth therein.
- The hospital will continue to maintain all criteria required of a Pediatric Ready Emergency Department.
- I will immediately notify the KYEMSC Project Director if this hospital is unable to meet the required criteria at any time during the recognition period.
- All information provided in or with this application is truthful and accurate to the best of my knowledge.
- All responses to the questions are full and complete, omitting no material information.
- I understand that all data submitted in or with this application may be subject to an Open Records request.
- I will allow representatives of the Kentucky Emergency Medical Services for Children Program and the Kentucky Pediatric Emergency Care Coalition to perform on-site reviews of the hospital to verify compliance with recognition standards.
- I acknowledge that the designated nurse or physician PEC Coordinator is expected to participate in at least one site visit to another facility during the 3 year recognition period.
- Pursuant to the articles of incorporation, bylaws, or resolution of the Board of Directors, I am authorized to submit this application on behalf of the hospital and bind it.

CEO Signature _____ Date: _____

Typed Name: _____

Pediatric Emergency Care Coordinator Signature _____ Date: _____

_____ Nurse Physician

Typed Name: _____

Pediatric Emergency Care Coordinator Signature _____ Date: _____

_____ Nurse Physician

Typed Name: _____