



INLAND COUNTIES EMERGENCY MEDICAL AGENCY
Serving San Bernardino, Inyo, and Mono Counties
1425 SOUTH "D" STREET
SAN BERNARDINO, CA 92415-0060
909-388-5823 FAX: 909-388-5825

**TRAUMA CARE SYSTEM DESIGNATION
LEVEL I AND II
APPROVAL APPLICATION**

- Level I
- Level II

Application Fee: \$5,000

I. HOSPITAL INFORMATION

Name: _____

Address: _____
Number & Street City State Zip

Contact: _____
Name Title

Phone #: _____ E-mail: _____

II. STAFFING REQUIREMENTS

Medical Directors (Attach resumes, copies of board certification and medical staff privileges)

Proposed Trauma Medical Director:

Name: _____

Phone #: _____ E-mail: _____

Board-certified surgeon or an ACS Fellow with a special interest in trauma care (Level I only)? Yes No

Proposed Trauma Program Emergency Department Representative: (Attach resume)

Name: _____

Phone #: _____ E-mail: _____

Board certified in Emergency Medicine? Yes No

Proposed Trauma Program Nurse Manager/Director: (Attach resume)

Name: _____

Phone #: _____ E-mail: _____

Proposed Trauma Performance Improvement Nurse: (Attach resume)

Name: _____

Phone #: _____ E-mail: _____

III. TRAUMA CENTER REQUIREMENTS

A. Level of ACS verification:

Level I

Level II

Date of next survey visit and level of verification: _____.

B. Do you have a minimum of 1,200 trauma hospital admissions annually, a minimum of 240 trauma patients per year with an Injury Severity Score (ISS) greater than 15, or an average of 35 trauma patients (with an ISS greater than 15 per trauma program surgeon per year). Yes No

C. Number of annual count of trauma hospital admissions: _____

D. Number of annual count of trauma patients with ISS greater than 15: _____

E. Do you have the following services on-call and promptly available?

Cardiothoracic Yes No

Pediatrics Yes No

Neurologic Yes No

Obstetric/Gynecological Yes No

Ophthalmologic Yes No

Oral, maxillofacial or head and neck Yes No

Orthopedic Yes No

Plastic Yes No

Urologic Yes No

F. Do you have the following nonsurgical specialists?

Anesthesiology Yes No

Internal Medicine Yes No

Pathology Yes No

Psychiatry Yes No

Radiology Yes No

G. Do you have OR staff immediately available with back-up personnel promptly available? Yes No

H. Do you have cardiothoracic surgery capabilities available 24 hours per day? Yes No

- I. Do you have cardiopulmonary bypass equipment (CPB)? Yes No
- J. Do you have an operating microscope available 24 hours per day? Yes No
- K. Do you have an Orthopedic trauma OR available daily? (Level I only) Yes No
- L. Do you have Anesthesiology in-house immediately available? (Level I only) Yes No
- M. Do you have an ICU with specialist in- house and immediately available to care for trauma patients? Yes No
- N. Is the ICU physician team led by a physician board certified in surgical critical care? Yes No
- O. Do you have the following services available for consultation or consultation and transfer? (Attach a copy of the agreement if you consult and transfer)
- Burns Yes No
- Re-implantation/microsurgery Yes No
- Spinal cord injury management Yes No
- P. Do you have the following approved supplemental services pursuant to California Code of Regulations, Title 22, Chapter 1, Division 5, Section 70301?
- Intensive Care Yes No
- Burn Center (this may be provided through a written transfer)
(If no, attach a copy of the agreement) Yes No
- Physical Therapy Yes No
- Rehabilitation Center (this may be provided through a written transfer with a rehabilitation center, attach a copy of the agreement) Yes No
- Respiratory Care Yes No
- Acute Hemodialysis capability Yes No
- Occupational Therapy Yes No
- Speech Therapy Yes No
- Social Service Yes No
- Q. Do you have one (1) full-time equivalent registrar dedicated to the registry to process the data capturing the ICEMA identified data sets for each 500 - 750 patients in the registry? Yes No
- R. Is your PICU approved by the California State Department of Health Services, California Children Service (CCS) or a written transfer agreement with an approved pediatric ICU? (Provide a copy of the approval or written agreement) Yes No
- S. Do you have an outreach program to include trauma prevention for the general public? Yes No
- T. Do you have a Trauma research program? Yes No

- U. Do you have an ACGME approved surgical residency program? Yes No
- V. Do you have a dedicated radio or phone line, capable of being answered 24 hours per day, 7 days per week, for paramedic notification of Trauma patients? Yes No
- W. Do you have tiered trauma activation criteria? (attach a current copy) Yes No
- X. Does your trauma center participate in regional disaster management plans and exercises? Yes No
- Y. Is a trauma panel surgeon a member of the disaster committee? (Level I only) Yes No
- Z. Does the policy include the diversion of trauma patients that is compliant with ICEMA policy? Yes No
- AA. Does the hospital have a policy regarding prompt acceptance of trauma patients from other trauma referral hospitals? Yes No
- BB. Does the hospital provide continuing education opportunities for EMS personnel? Yes No

On behalf of the above named hospital and physicians, I agree to all provisions identified in ICEMA Reference #4110 - Trauma Care System Designation.

Signature - Chief Executive Officer

Date

Print Name

Submit the completed application and fee to ICEMA, attention to Loreen Gutierrez, Specialty Care Coordinator. Questions may be directed to her at (909) 388-5803, or via e-mail at loreen.gutierrez@cao.sbcounty.gov.