APPLICATION FOR CENTER OF EXCELLENCE DESIGNATION

Contact Information

_____
Name of Organization

_____
Address, City, State, Zip

_____ _____
Name of Contact Person Title

_____ _____ _____
E-mail Phone Fax

URL for Organization's Website: _____

Center of Excellence Designation(s) Requested:

- ☐ Center of Excellence in Long Term Acute Care
- ☐ Center of Excellence in Rehabilitation Services
- ☐ Center of Excellence in Environmental Health & Safety
- ☐ Center of Excellence in Respiratory Therapy
- ☐ Center of Excellence in Nursing Services

Accrediting Information

Who is the hospital's current accreditor / certifier? (*select one only*)

- ☐ Center for Improvement in Healthcare Quality (CIHQ) Expiration Date: _____
- ☐ Det Norske Veritas (DNV) Expiration Date: _____
- ☐ Healthcare Facilities Accreditation Program (HFAP) Expiration Date: _____
- ☐ The Joint Commission (TJC) Expiration Date: _____
- ☐ Directly Certified by CMS Date Last Surveyed: _____

_____ _____
Signature of Person Submitting Application Date

_____
Name / Title

Mail To:
CIHQ
P.O. Box 3620
McKinney, TX 75070

Fax To:
(805) 934-8588
Fax is to a secure location

Register by Phone Toll Free
(866) 324-5080
(8AM – 4:30PM PT)