APPLICATION FOR DISEASE SPECIFIC CERTIFICATION

Contact Information

Name of Organization

Address, City, State, Zip

Name of Contact Person

Title

E-mail

Phone

Fax

URL for Organization’s Website:

Disease Specific Certification(s) Requested:

☐ Disease Specific Certification in Acute Stroke Ready Hospital
☐ Disease Specific Certification in Primary Stroke Center
☐ Disease Specific Certification in Comprehensive Stroke Center
☐ Disease Specific Certification in Heart Failure
☐ Disease Specific Certification in Joint Replacement Surgery
☐ Disease Specific Certification in Thrombectomy Capable Stroke Center

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

Name / Title

Date

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)