Center for Improvement
CIHQ
in Healthcare Quality

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 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)