



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
- Center of Excellence in Palliative Care
- Center of Excellence in Emergency 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)