MEMBERSHIP APPLICATION & REGISTRATION FORM
HOSPITALS

Name of Entity: _____

Office Phone: _____ _

Physical Address: _____City:_____ State: _____ Zip: _____

Mailing Address: _____City: _____ _____ State: _____ Zip: _____

CEO or Chief: _____Phone# _____ email: _____

CNO_____

Email Address (please print) _____ Cell: _____

RAC Representative: _____

Email Address (please print) _____ Cell: _____

Office Phone: _____

1. Alternate Representative: _____

Email Address (please print) _____ _____Cell: _____

Office Phone: _____ _____

2. Alternate Representative: _____

Email Address (please print) _____ Cell: _____

Office Phone: _____ ___

Hospital License # _____ # of Beds _____ # ER Beds_____ # of Isolation Beds_____ # of Critical Care Beds _____

Trauma Level Held: Level_____ Trauma Coordinator: _____

Maternal level_____Coordinator_____

Neonatal level_____Coordinator_____

Cardiac Level_____Coordinator_____

Stroke Level_____Coordinator_____

ED Medical Director**:** _____ Phone: _____

Trauma Medical Director_____Phone_____

Ed Medial Director's Emergency Contact Number (24/7) _____

Who provides 24 hour coverage in your ER? (Circle one) MD PA NP

Please check the types of services your facility can provide for a patient: (Check all that apply):

□General Surgery	24 hour coverage yes_____ NO_____
□Orthopedic Surgery	24 hour coverage yes_____ NO_____
□Neurosurgery Surgery	24 hour coverage yes_____ NO_____
□Neurology	24 hour coverage yes_____ NO_____
Maternal/Obstetrician	24 hour coverage yes_____NO_____
Neonatologist	24 Hour coverage yes_____NO_____
Pedi	yes_____ No_____
Rehab	yes_____NO_____

Signature: _____ Date: _____
_____By typing in name will substitute for signature

Return with completed application to: executivedirector@cvrac.org
Texas J RAC
P.O. Box 76906
San Angelo TX 76906