

QUALITY PROGRAMS of the AMERICAN COLLEGE OF SURGEONS

RESOURCE GUIDE

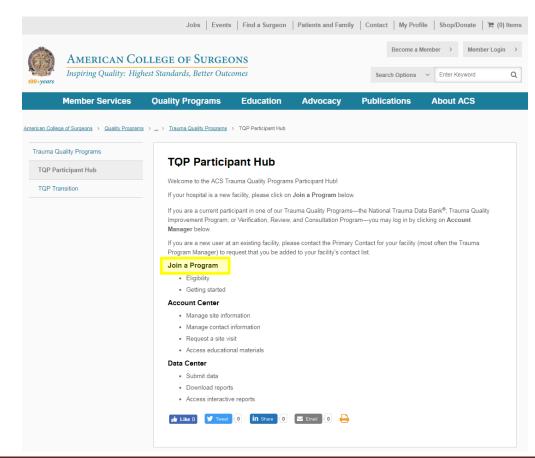
Register a New Facility and Apply for an ACS Trauma Quality Program

Purpose

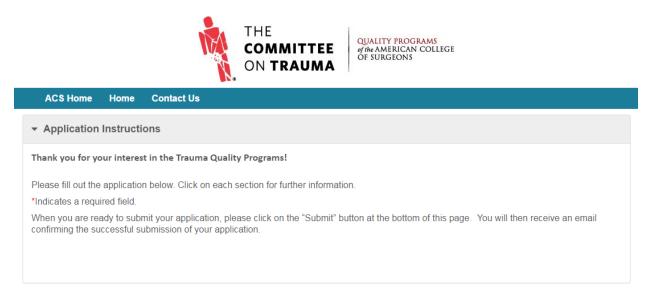
The purpose of this guideline is to outline the process for **new centers** of applying for one of the ACS Trauma Quality Programs and creating an account.

Process

1. From the Trauma Quality Programs Participant Hub, click "Join a Program." If you are a new user at an existing facility, please contact the Primary Contact for your facility (most often the Trauma Program Manager) to request that you be added to your facility's contact list.



2. The "Application Instructions" section provides an overview of how to complete the online application. The required fields (noted by a red asterisk) in each section must be completed before the application can be submitted.



3. The "Program Selection" section allows you to select the ACS Trauma Quality Program you are applying to. If you are interested in becoming an ACS Verified Trauma Center, you may list the Adult and/or Pediatric Verification Levels you are pursuing here. If you are planning to join an existing TQIP Collaborative, you may select the Collaborative you wish to join from the drop-down list.

Program Selection		
*Select the ACS Trauma Quality Program you are applying to:	Select One	•
Which ACS Trauma Verification Levels are you interested in pursuing?		
*Adult Trauma Level:	Select One	¥
*Pediatric Trauma Level:	Select One	•
*Are you planning to be part of a TQIP Collaborative?	O Yes O No	
If so, select the Collaborative:	Select One	¥

4. Hospital address information should be entered in the "Facility Information" section. The *Federal Employer Identification Number* field asks for your facility's unique 9-digit number assigned by the Internal Revenue Service (IRS) to all businesses operating in the United States. The *Tax ID Number if Outside USA* field should be completed by international facilities only, and asks for their facility's national identification number.

▼ Facility Information						
United States	ntification Number: asks for your facility's unique 9-digit number assigned by the Internal Revenue Service (IRS) to all businesses operating in the ide USA: should be completed by international facilities only, and asks for their facility's national identification number					
*Company Name:						
*Address:						
*Country:	United States •					
*City:						
*State:	Select One 🔹					
*ZIP:						
*Telephone:						
FAX:						
Company Email:						
*Web Site:						
*Federal Employer Identific	ation Number (FEIN): (Required for US)					
National Provider Identifier	Number (NPI):					
Tax ID Number if Outside U	SA:					

5. The "Trauma Center Level" section allows you to indicate the level of state designation your trauma center has, if applicable.

▶ Trauma Center Level		
*State Adult Trauma Designation Level:	Select One	•
*State Pediatric Trauma Designation Level:	Select One	Ŧ

6. For the initial application, contact information for a Data Primary Contact and Trauma Medical Director is required in the "Contact Information" section. Additional contacts may be added or updated upon approval of the application.

Contact Information							
Please provide contact information for the roles below, as appropriate. At least one Primary Contact must be identified at this time. The Primary Contact will receive notifications regarding application status. Additional roles and contacts may be added or updated at a later time.							
The Data Primary Contact will have the ability to add, edit, and remove contacts once the application is approved.							
Data Primary Contact (Required)		Trauma Medical I	Director (Required)				
Use Facility Address:		Use Facility Address:					
Primary Contact:		Primary Contact:					
*First:		*First:					
*Last:		*Last:					
Credentials		Credentials					
*Title:		*Title:					
*Email:		*Email:					
*Telephone:	*Area Code: *Number:	*Telephone:	*Area Code: *Number:				
*Address		*Address					
*Country:	United States •	*Country:	United States •				
*City		*City					
*State:	Select One 🔻	*State:	Select One 🔹				
*ZIP:		*ZIP:					

7. Please enter your name and title in the "Application Authorization" section. You must check the "Agree" box before submitting the application.

Application Authorization					
Please verify that information entered here is an accurate representation of your facility.					
*Your Name					
*Your Title					
	Agree				
	Submit Pre-Application				

8. After submitting the application, you will receive an email confirming your submission. If desired, you may print or save a copy of your application by clicking "Print PreApplication" on the next screen. A member of the ACS Trauma Quality Programs staff will contact you within 5 business days after receiving your application.



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