

Applicant's Name:	Completed by:	Date:
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URGENT CARE/EMERGICENTER SUPPLEMENTAL APPLICATION

1. Are beds maintained for overnight occupancy? (If 'Yes', please explain in the Comments Section).	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Are there any licensed hospital beds? (If 'Yes', please explain in the Comments Section).	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Is a board certified (board eligible) physician onsite during hours of operation with at least 2 years emergency department experience? (If 'No', please explain in the Comments Section).	<input type="checkbox"/> YES <input type="checkbox"/> NO
4. Please check-off the following policies and procedures that are established and adhered to by all employees. (Please explain any No answers in the Comments Section).	
a. Only ED skilled nurses/physicians are accountable for conducting triage, determining acuity level / appropriateness for transfer to in-patient facility	<input type="checkbox"/> YES <input type="checkbox"/> NO
b. Strict rule of myocardial infarction via detailed history/physical and liberal transfer to an acute care setting	<input type="checkbox"/> YES <input type="checkbox"/> NO
c. Strict rule out of fractures via protocols that include: written patient instructions to return for re-examination if pain persists for 12 hours, over read by radiologists, and notifying patients of any latent abnormal findings	<input type="checkbox"/> YES <input type="checkbox"/> NO
d. The restriction on telephone orders and advice without being seen by a physician	<input type="checkbox"/> YES <input type="checkbox"/> NO
e. Vital signs (temp, bp, respiration) and pulse oximetry on all patients presenting to the facility with a respiratory complaint or shortness of breath	<input type="checkbox"/> YES <input type="checkbox"/> NO
f. Written discharge instructions (copy to patient)	<input type="checkbox"/> YES <input type="checkbox"/> NO
5. Please check-off the following components of your formal Quality/Risk Management Program if they are established and adhered to. (Please explain any 'No' answers in the Comments Section).	
a. Ongoing review of medical records against specific outcome criteria (patients who return within a specified amount of time with the same complaint, admission to the acute care setting post discharge, complaints, AMA's etc.)	<input type="checkbox"/> YES <input type="checkbox"/> NO
b. Medical devices involved in patient injuries	<input type="checkbox"/> YES <input type="checkbox"/> NO
c. Audits to determine medical record documentation compliance	<input type="checkbox"/> YES <input type="checkbox"/> NO
d. Incident reporting processes	<input type="checkbox"/> YES <input type="checkbox"/> NO

Comments Section: _____
