Name of hospital and address (typed)

1. Specify the recognition level for which your hospital is applying:

   ☐ Emergency Department Approved for Pediatrics (EDAP)

   ☐ Stand-by Emergency Department Approved for Pediatrics (SEDP)

2. The above-named hospital certifies that each requirement in this Request for Recognition is met and will be in operation by the date of recognition.

_____

Typed name - CEO/Administrator

_____   _____

Signature - CEO/Administrator   Date

_____

Typed name - Medical Director of Emergency Services

_____   _____

Signature - Medical Director of Emergency Services   Date

_____

Contact person - typed name, credentials, and title

_____

Contact person - phone number, fax number, and e-mail