### ILLINOIS EMSC

### FACILITY RECOGNITION

### Request for Re-recognition of EDAP or SEDP Status

Name of hospital and address (typed)

|  |
| --- |
| Click here to enter text. |
| Click here to enter text. |
| Click here to enter text. |
| Click here to enter text. |

|  |  |
| --- | --- |
| 1. Specify the recognition level for which your hospital is applying for renewal: |  |
| * Emergency Department Approved for Pediatrics (EDAP) |  |
| * Stand-by Emergency Department Approved for Pediatrics (SEDP) |  |
|  |  |
| 1. The above named facility certifies that each requirement in this Request for Recognition is met. | |

|  |
| --- |
| Click here to enter text. |
| Typed name – CEO/Administrator |
| Signature - CEO/Administrator Date  Click here to enter text. |
| Typed name – Medical Director of Emergency Services |
| Signature – Medical Director of Emergency Services Date    Click here to enter text. |
| Contact person - Typed name, credentials and title  Click here to enter text. |
| Contact person - phone number, fax number and email |