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 **Membership Contact Information: Hospital**

***Please type or print clearly***

Information provided will only be shared with CATRAC staff and CATRAC members for business and emergency purposes.

Top of Form

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| Facility Name:  |
| Texas License Number: | NPI (National Provider Identifier): |
| Check any that apply:[ ]  General Hospital [ ]  Special Hospital [ ]  Surgical Center Hospital [ ]  Behavioral Health Hospital [ ]  Rehabilitation Hospital[ ]  Trauma Designated (Level: \_\_) [ ]  Stroke Designated (Type: \_\_) [ ]  Cardiac Type (PCI or Non-PCI) (Type: \_\_) [ ]  Neonatal Designated (Level: \_\_) [ ]  Other (Please Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_)  |
| Website URL:  |
| Physical Address: |
| Mailing Address: |
| County: | House Supervisor Phone:  |
| Main Office Phone:  | Fax: |

Bottom of Form

Please complete the following and include each contact’s NAME, EMAIL and PHONE(S)**.**

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| 24/7 contact for CATRAC to use for emergency notifications of incidents or events: |
| Name: | Email: | Office Phone: | Cell Phone: |
| Contact for routine information or business questions: |
| Name: | Email: | Office Phone: | Cell Phone: |
| General Membership **DESIGNATED** CATRAC Voting Member:(Designated voting member **or** alternate voting member are required to attend 75% of General Membership meetings) |
| Name: | Email: | Office Phone: | Cell Phone: |
| General Membership **ALTERNATE** CATRAC Voting Member: (Designated voting member **or** alternate voting member are required to attend 75% of General Membership meetings) |
| Name: | Email: | Office Phone: | Cell Phone: |
| Administrator: |
| Name: | Email: | Office Phone: | Cell Phone: |
| Administrator’s Assistant: |
| Name: | Email: | Office Phone: | Cell Phone: |
| CEO: |
| Name: | Email: | Office Phone: | Cell Phone: |
| CEO’s Assistant: |
| Name: | Email: | Office Phone: | Cell Phone: |
| COO: |
| Name: | Email: | Office Phone: | Cell Phone: |

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| (CONT.) Please complete the following and include each contact’s NAME, EMAIL and PHONE(S) |
| COO’s Assistant**:** |
| Name: | Email: | Office Phone: | Cell Phone: |
| Site Safety Officer or Emergency Manager**:** |
| Name: | Email: | Office Phone: | Cell Phone: |
| Public Information Officer**:** |
| Name: | Email: | Office Phone: | Cell Phone: |
| Education Coordinator/Manager:(If more than one, please list their contact information and educational area) |
| Name: | Email: | Office Phone: | Cell Phone: |
| Emergency Department Medical Director (physician): |
| Name: | Email: | Office Phone: | Cell Phone: |
| Emergency Department Manager / Director: |
| Name: | Email: | Office Phone: | Cell Phone: |
| Trauma Medical Director (physician): |
| Name: | Email: | Office Phone: | Cell Phone: |
| Trauma Manager/Director: |
| Name: | Email: | Office Phone: | Cell Phone: |
| Trauma Coordinator: |
| Name: | Email: | Office Phone: | Cell Phone: |
| Stroke Medical Director (physician): |
| Name: | Email: | Office Phone: | Cell Phone: |
| Stroke Coordinator: |
| Name: | Email: | Office Phone: | Cell Phone: |
| Cardiac Medical Director: |
| Name: | Email: | Office Phone: | Cell Phone: |
| Chest Pain Coordinator: |
| Name: | Email: | Office Phone: | Cell Phone: |
| Infection Preventionist /Infection Control Nurse: |
| Name: | Email: | Office Phone: | Cell Phone: |
| Neonatal Medical Director (physician): |
| Name: | Email: | Office Phone: | Cell Phone: |
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|  |  |  |  |
| Neonatal Program Manager/Director: |
| Name: | Email: | Office Phone: | Cell Phone: |
| Maternal Medical Director (physician): |
| Name: | Email: | Office Phone: | Cell Phone: |
| Maternal Program Manager/Director: |
| Name: | Email: | Office Phone: | Cell Phone: |

**CATRAC COMMITTEES:**

Per CATRAC Organizational Bylaws, participation in committees is expected of all member agencies, and attending 75% or more of meetings for eligibility. Along with great networking opportunities among your regional partners, sharing of best practices, and information exchange on local, regional and statewide levels, membership participation allows your organization to be eligible for grant funding opportunities the CATRAC is involved in, as well as subsidized educational offerings. Participation on more than one committee is encouraged to help bring a multi-disciplinary approach to the committees and if a hospital has multiple service lines.

* Please include **NAME, EMAIL and PHONE** for each committee participant.
* You may add more than one person per committee.

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| Pre-Hospital Committee: |
| Name: | Email: | Office Phone: | Cell Phone: |
| Education Committee: |
| Name: | Email: | Office Phone: | Cell Phone: |
| Trauma Systems & Operations Committee: |
| Name: | Email: | Office Phone: | Cell Phone: |
| Injury Prevention Committee: |
| Name: | Email: | Office Phone: | Cell Phone: |
| Stroke Committee: |
| Name: | Email: | Office Phone: | Cell Phone: |
| Regional Preparedness & Response Committee and Capital Area Public Health & Medical Preparedness Coalition Representative: |
| Name: | Email: | Office Phone: | Cell Phone: |
| Perinatal/Maternal Workgroup: |
| Name: | Email: | Office Phone: | Cell Phone: |
| Cardiac/Mission Lifeline: |
| Name: | Email: | Office Phone: | Cell Phone: |

Please complete the following for CATRAC membership renewal**.**

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| **Billing Address:** |
| **Accounts Payable Department Contact:** |
| Name:  | Email:  | Office Phone:  |

**Application Approved By:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Administrator, CEO, or COO signature) (Date)

This form should be signed and forwarded to the administrative coordinator, Melissa Hamaker, at 512-926-2777 (fax) or email at mhamaker@catrac.org. This form can be downloaded at www.catrac.org