



Application Signature Page

Name and address of hospital (typed)

Hospital
Name:

Hospital
Address:

The above named facility is requesting

Designation / Redesignation

as a

- Comprehensive Stroke Center
- Thrombectomy Capable Stroke Center
- Thrombectomy Ready Stroke Center
- Primary Stroke Center Plus
- Primary Stroke Center
- Acute Stroke-Ready Hospital with National Certification

In addition, the above named facility certifies that each requirement in this Stroke Center Designation Application is met.

Typed name – CEO/Administrator

Signature - CEO/Administrator

Date

Typed name – Hospital Stroke Medical Director

Signature – Hospital Stroke Medical Director

Date

Contact Person – Typed name, credentials, and title

Contact Person – Phone number, fax number, and email



INSTRUCTIONS

Review the following instructions carefully:

- Provide the requested documentation for each requirement listed.
- Utilize the Application Checklist to ensure all required documentation is received by IDPH.
- Submit the completed Application Checklist with your application.
- Every application submitted must include a completed signature page.
- Choose the appropriate stroke designation for your hospital from the drop down options in the Title Section of the Application Checklist.
- The required statement can be in letter format signed by the CEO or Stroke Director stating the hospital meets the requirements for a Comprehensive Stroke Center, Thrombectomy Capable Stroke Center, Thrombectomy Ready Stroke Center, Primary Stroke Center Plus, Primary Stroke Center, or Acute Stroke Ready Hospital with National Certification set forth in Section 3.117 of the Act.
- Include any applicable supplemental documentation.
- Contact the Illinois Department of Public Health Stroke Program coordinator with any questions regarding this application or required documents at 217-785-2080.

Submit all stroke documentation in PDF format in the order of the application to:

Michelle Lear, RN Stroke Program Coordinator
Michelle.lear@illinois.gov



Application Checklist

Facility Checklist	Required Documentation	IDPH Use Only
	Hospital Name Attach documentation certifying the hospital is currently certified as a/an by a nationally recognized certifying body approved by the Illinois Department of Public Health. Dates of current certification _____	
	Attach statement that the hospital meets the requirements for Designation in Section 3.117 of the Act.	

For Illinois Department of Public Health Use Only

Approved

Denied

Signature of Stroke Program Manager or Designee

Date