Washington State Department of HEALTH

Community Health Systems
PO Box 47853
Olympia WA, 98504-7853

Level 2 Stroke Center Certification Statement

I, _____ (CEO/COO), on behalf of _____ (hospital), voluntarily agree to participate in the Washington State Emergency Cardiac and Stroke System as a Level II Stroke Center. We will work with emergency medical services and other hospitals in our area to streamline triage and transport of stroke patients and participate in regional quality improvement activities, as available.

By my initials and signature, I certify that:

____ The information and documentation provided in this application is true and accurate.

____ We will participate in a state or national data collection system that measures stroke system performance from patient onset of symptoms to treatment or intervention, as required by RCW 70.168.150.

____ We will notify the Department of Health immediately if we are unable to provide the level of stroke service we've committed to in this application.

This hospital is:

_____ Certified as a Comprehensive Stroke Center by one of these national accrediting organizations (check one). Proof of certification is attached to this Certification Statement. (Note: certified hospitals DO NOT have to complete the application other than Section A and B.)

☐ Joint Commission; Certification Period: _____

☐ DNV Healthcare Inc., Certification Period: _____

☐ HFAP; Certification Period: _____

-OR-

_____ This hospital meets the criteria to be categorized as a Level II Stroke Center as defined in the criteria checklist of this application, and provides these services 24/7.

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

Chair, Governing Entity (Hospital Board)	Date
Chief Executive Officer	Date
Stroke Program Medical Director	Date
Stroke Program Coordinator	Date
Emergency Department Medical Director	Date
Quality Director	Date