State of Illinois
Illinois Department of Public Health

STROKE CENTER DESIGNATION APPLICATION

Request for Designation/Re-Designation of
Comprehensive Stroke Center, Primary Stroke Center or
Acute Stroke-Ready Hospital with National Certification

Application Signature Page

Name and address of hospital (typed)

Hospital Name:

Hospital Address:

The above named facility is requesting

❑ Designation / ❑ Re-Designation

as a

❑ Comprehensive (CSC), ❑ Primary Stroke Center (PSC) or

❑ Acute Stroke-Ready Hospital (ASRH) with National Certification

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

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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 the Department.
- 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, 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.

Send all stroke documentation to:

Stroke Program Coordinator
Illinois Department of Public Health
422 S. 5th St., 3rd Floor
Springfield, IL 62701

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Application Checklist

Select One

Facility Checklist	**Required Documentation** Hospital Name	IDPH Use Only
	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