Department of State Health Services (DSHS)
EMS/Trauma Systems (EMS/TS)
Uncompensated Trauma Care Application
Discharged Patients Data Calendar Year 2023

Due April 20, 2025

PART B – AFFIDAVIT
(NOTE: This form must be completed **with required signatures individually notarized** to be eligible for funding).

Hospital Name: _____

I, _____, **Chief Executive Officer/Trauma Hospital Administrator** for the hospital named above, swear, or affirm that the information contained in this application is true and correct. I also swear or affirm that I have fully read and understand the stipulations listed in this application.

Notary Information (REQUIRED):

Subscribed and sworn before me, a Notary Public, on _____ (date).

_____ _____

Notary Public (Print) Notary Public (Signature)

County: _____ My Commission expires: _____

State of: _____ **Notary Stamp Here**:

Chief Executive Officer:

_____ _____

Name (print) Signature

Department of State Health Services (DSHS)
EMS/Trauma Systems (EMS/TS)
Uncompensated Trauma Care Application
Discharged Patients Data Calendar Year 2023

Due April 20, 2025

PART B – AFFIDAVIT
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Hospital Name: _____

I, _____, **Chairman of the Board of Directors** for the hospital named above, swear, or affirm that the information contained in this application is true and correct. I also swear or affirm that I have fully read and understand the stipulations listed in this application.

Notary Information (REQUIRED):

Subscribed and sworn before me, a Notary Public, on _____ (date).

_____ _____

Notary Public (Print) Notary Public (Signature)

County: _____ My Commission expires: _____

State of: _____ **Notary Stamp Here**:

Chairman of the Board of Directors:

_____ _____

Name (print) Signature

Department of State Health Services (DSHS)
EMS/Trauma Systems (EMS/TS)
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PART B – AFFIDAVIT
(NOTE: This form must be completed **with required signatures individually notarized** to be eligible for funding).

Hospital Name: _____

I, _____, **Chief Financial Officer** for the hospital named above, swear, or affirm that the information contained in this application is true and correct. I also swear or affirm that I have fully read and understand the stipulations listed in this application.

Notary Information (REQUIRED):

Subscribed and sworn before me, a Notary Public, on _____ (date).

_____ _____

Notary Public (Print) Notary Public (Signature)

County: _____ My Commission expires: _____

State of: _____ **Notary Stamp Here**:

Chief Financial Officer:

_____ _____

Name (print) Signature

Department of State Health Services (DSHS)
EMS/Trauma Systems (EMS/TS)
Uncompensated Trauma Care Application
Discharged Patients Data Calendar Year 2023

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PART B – AFFIDAVIT
(NOTE: This form must be completed **with required signatures individually notarized** to be eligible for funding).

Hospital Name: _____

I, _____, **Chief Nursing Officer** for the hospital named above, swear, or affirm that the information contained in this application is true and correct. I also swear or affirm that I have fully read and understand the stipulations listed in this application.

Notary Information (REQUIRED):

Subscribed and sworn before me, a Notary Public, on _____ (date).

_____ _____

Notary Public (Print) Notary Public (Signature)

County: _____ My Commission expires: _____

State of: _____ **Notary Stamp Here**:

Chief Nursing Officer:

_____ _____

Name (print) Signature

Department of State Health Services (DSHS)
EMS/Trauma Systems (EMS/TS)
Uncompensated Trauma Care Application
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PART B – AFFIDAVIT
(NOTE: This form must be completed **with required signatures** to be eligible for funding).

Hospital Name: _____

I, _____, **Trauma Medical Director** for the hospital named above, acknowledge that a copy of this application was made available for my review.

Trauma Medical Director:

_____ _____

Name (print) Signature

I, _____, **Trauma Program Manager** for the hospital named above, acknowledge that a copy of this application was made available for my review.

Trauma Program Manager:

_____ _____

Name (print) Signature