



**Department of State Health Services (DSHS)  
EMS/Trauma Systems (EMS/TS)  
Uncompensated Trauma Care Application  
Discharged Patients Data Calendar Year 2024  
Due February 25, 2026**

**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



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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



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**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



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**PART B – AFFIDAVIT**

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**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



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**PART B – AFFIDAVIT**

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**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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date