[Collaborative Name] Application Form

FACILITY INFORMATION

Hospital Name: Address (line 1):
Address (line 2):
City, State:
Zip Code:
ACS COT Accreditation: ☐ I ☐ II ☐ III

FACILITY CONTACTS

Trauma Director Name (or equivalent):
Title:
Email:
Phone:
Fax:

Surgeon Champion Name (if different from above):
Title:
Email:
Phone:
Fax:

Trauma Program Manager Name:
Title:
Email:
Phone:
Fax:

Trauma Registrar Name:
Title:
Email:
Phone:
Fax:

Primary Contact Name:
Address:
City, State:
Zip Code:

REQUEST

- ☐ Request for information only
- ☐ Request for membership
- ☐ Other:

Submit application via email to [Email Address]