ACS NSQIP

APPLICATION FORM

APPLICATION MUST BE COMPLETED IN ITS ENTIRETY

I. FACILITY IDENTIFICATION

Name of Hospital

Address (line 1)

Address (line 2)

City/State/ZIP Code

Hospital FEIN #

AHA ID#
(American Hospital Association Identification Number)

System Affiliation

CEO (or equivalent) Name

Title

E-mail Address

Telephone Number Fax Number

Primary Legal Contact Name

Title

Address (line 1)

Address (line 2)

City/State/ZIP Code

E-mail Address

Telephone Number Fax Number

II. PROGRAM CONTACTS

Designated Surgeon Champion Name

Title

Address (line 1)

Address (line 2)

City/State/ZIP Code

E-mail Address

Telephone Number Fax Number

If the designated surgeon is not the chief of surgery, please provide the chief of surgery's name below:

Primary Program Contact Name

Title

Address (line 1)

Address (line 2)

City/State/ZIP Code

E-mail Address

Telephone Number Fax Number

III. HOSPITAL INFORMATION

Accreditation	☐JCAHO ☐AOA ☐Other; please identify accrediting body:_____
Classification	☐Class I or General Hospital ☐Class II Hospital (Special Children/Women) ☐Class III Hospital (Special Medical/Psychiatric/Eye/Rehabilitation/Substance abuse) ☐Class IV Hospital (Intensive Residential Treatment Facility)
	Is your hospital a trauma center? ☐ Yes ☐No If yes, what level? _____
Description	☐Public ☐Not for profit ☐For profit
Volume	A. How many licensed beds? ☐Less than 100 ☐100-300 ☐300-500 ☐More than 500
	B. Does your hospital meet the high-volume case requirement of 1,680 general and vascular cases annually? ☐Yes ☐ No (if No, answer C below)
	C. If you answered No to B above, does your hospital meet the low-volume case requirement of: 1. 900 general and vascular surgery cases annually? ☐Yes ☐ No 2. 900 cases including general and vascular surgery, urology, neurosurgery, orthopaedics, otolaryngology, plastic surgery, thoracic surgery, and gynecologic surgery? ☐Yes ☐ No
Data Collection	To help us prioritize the development of new models, please indicate the top 5 specialties at your hospital that would benefit most from ACS NSQIP expansion.

Specialty:			
☐Bariatric	☐Oral	☐Pediatric	☐Thoracic
☐Gynecology	☐Orthopaedics	☐Plastic/Reconstructive	☐Trauma
☐Neurosurgery	☐Otolaryngology (ENT)	☐Podiatry	☐Urology
☐Ophthalmology	☐ Other, please specify:		

Data Use	How do you plan to use the ACS NSQIP data? Check all that apply: ☐Quality improvement ☐Marketing ☐Patient education ☐Reimbursement negotiation ☐Research ☐Teaching and training of clinical staff/residents ☐National benchmarking ☐Multihospital system benchmarking, resource utilization ☐Don't know
Funding	Do you have budget approval and funding to hire a surgical clinical nurse reviewer to capture your site's clinical data? ☐Yes ☐No

IV. GENERAL INFORMATION

Referral Sources	☐ACS Clinical Congress ☐Direct mail ☐Internet ☐VA/QC Metrix/COHO ☐Other Please identify other source: _____
Application	A. What model are you applying for? ☐ General/vascular high volume ☐ General/vascular reduced volume ☐ Multispecialty ☐ Bariatric B. Have you filed an application before? ☐Yes ☐No
Enrollment	On what date are you able to enroll in the program?_____

V. COMMENTS

State any additional information you believe may be helpful to us in considering your application:

VI. INFORMATION CONFIRMATION

I have read the ACS NSQIP information packet and understand the hospital responsibilities to participate in the program. My institution would like to participate in the program. Please consider this application.

Signature of chief executive officer: _____

Date: _____ 20____

Signature of surgeon champion: _____

Date: _____ 20____

SEND COMPLETED APPLICATION TO:
American College of Surgeons
Attn: Marchelle Werner, 25NE
633 N. Saint Clair St.
Chicago, IL 60611-3211
OR FAX TO:
312/202-5011
OR APPLY ONLINE AT:
www.acsnsqip.org