Ohio Department of Health

Hospital Registration
Stroke Level Recognition Form

Date _____

Hospital Name _____ Registration Number_____AHR

Street Address _____ City _____

County _____ State _____ ZIP _____

Is the above location an off-site satellite location reported on the hospital's annual report? ☐ Yes ☐ No

Hospital Contact Information:

Name _____

Phone _____

E-mail _____

Stroke Recognition Category Requested:

☐ Comprehensive Stroke Center

☐ Thrombectomy Capable Stroke Center

☐ Primary Stroke Center*

☐ Acute Stroke Ready Hospital

***Primary Stroke Center Supplemental Distinction (if applicable)**

Hospitals that receive ODH Recognition as a **Primary Stroke Center** that have also attained supplementary Levels of Stroke Care Distinction by an accrediting organization noted above may obtain a supplementary distinction if additional documentation is submitted from the accrediting organization recognizing the supplementary level of stroke care distinction.

Attach proof of Accreditation for the Category requested from one of the following entities:

☐ The Joint Commission _____ (Expiration date of accreditation mm/dd/yyyy)

☐ Accreditation Commission for Health Care – HFAP _____ (Expiration date of accreditation mm/dd/yyyy)

☐ DNV GL – Healthcare _____ (Expiration date of accreditation mm/dd/yyyy)

☐ Other (CMS approved Accrediting Organization) _____ (Expiration date of accreditation mm/dd/yyyy)

If certification by the accrediting organization is revoked, rescinded, or otherwise terminated, the hospital shall notify the Department in writing within 5 business days of receipt of such notice. Notice may be submitted to the e-mail address noted below.

Submit all forms and attachments to: AHR@odh.ohio.gov

If you need additional information, please contact the program at 614-466-3325.