STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Emergency Medical Services

HOSPITAL STROKE CENTER ATTESTATION OF CERTIFICATION OR RENEWAL

1. Application for Certification: Initial Start Date:_________ Certification Expiration Date: _________

   Renewal Certification Expiration Date:___________

2. Name of Hospital: ____

3. Address: ____

   ____
   City State Zip Code

4. Contact Person:____

5. Contact phone _______________________ Contact email:_______________________

6. Certification category (select below and attach a copy of the certificate):

   Comprehensive Stroke Center
   Primary Stroke Center
   Acute Stroke Ready Hospital
   Thrombectomy-Capable (TSC)

7. Certifying organization:

   American Heart Association
   Joint Commission
   Healthcare Facilities Accreditation Program (HFAP)
   Other Nationally recognized Certifying Organization

   Name of Organization ____

I hereby attest that: (1) I am authorized to execute this attestation on behalf of the hospital identified above; (2) the information set forth in this document and the attachment hereto are, to the best of my knowledge true and accurate; and (3) I will immediately inform the Department if the certification is suspended or revoked.

Authorized signature: ___________________________________ Title: _____________________

Printed name: ____ Date: _____________

To Submit and attach Certification

Phone: (860) 509-7975 • Fax: (860) 730-8384
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