CONNECTICUT
Public Health

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 Click to Submit

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