APPLICATION FOR INTENSIVE CARE NEWBORN NURSERY SERVICE

Reply to:

____
HOSPITAL NAME

1. Name and board eligibility or certification status and additional neonatology training or experience of the physician responsible for the service:

2. Name and board eligibility or certification status of anesthesiologist(s) available to the service:

3. Name and qualifications of the surgeon(s) performing neonatal surgery:

4. Name and qualifications of pediatric cardiologist(s) available to the service:

5. Name, training and newborn intensive care experience of the nurse responsible for the nursing care:

6. Is a registered nurse with training and experience on duty each shift? ☐ YES ☐ NO

7. Is a registered nurse trained in infant resuscitation on duty each shift? ☐ YES ☐ NO

8. Registered nurse to infant ratio/ shift: ________AM ________PM ________NIGHT

9. Does the service have a designated transportation team? ❑ YES ❑ NO

10. Name of the physician on the transportation team: ______________________________

11. Name and qualifications of the registered nurse assigned to the transportation team:

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12. Name of the respiratory therapist(s) on the transportation team, if provided: ______________________________

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13. List the referring perinatal units by hospital and address: ______________________________

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14. Number of beds, cribs and bassinets: Beds: __________ Cribs: __________ Bassinets: __________

15. Does the service provide continuing education for staff of referring perinatal units? ❑ YES ❑ NO