



NEONATAL FACILITY DESIGNATION APPLICATION LEVELS II, III, and IV

General Information

- For process, rule clarification, or technical assistance please contact:
Maternal and Neonatal Center Program Manager, Erin Smith, R.N
erin.smith@dph.ga.gov
- Submit the application packet to our office within 90 days of the facility's completed survey date.

Application Packet Submission Instructions:

1. Fill out the Application. Answer all questions completely.
2. Compile all required documents for the application packet including:
 - ☐ Completed designation application form for the appropriate level of designation with required signatures.
 - ☐ Letter of Intent.
 - ☐ Designation survey report, including medical record reviews.
 - ☐ Plan of correction, including supporting documentation, if appropriate.
 - ☐ Any additional documents requested by the Department of Public Health.
3. Electronically submit application packet to:
erin.smith@dph.ga.gov

Subject line: Designation Application Packet: [Facility Name]

If you do not receive a confirmation within 2 business days, please contact

[Neonatal Designation Program](#)



Kathleen E. Toomey, M.D., M.P.H., Commissioner

Brian Kemp, Governor

2 Peachtree Street, NW, 15th Floor
Atlanta, Georgia 30303-3142

dph.ga.gov

Neonatal Facility Designation Application – Level II, III, IV

Date:

Facility Name:

Licensed Street Address:

City, State, Zip:

County:

Mailing Address (if different):

City, State, Zip:

Perinatal Care Region (PCR):

Facility Level: Level II ☐ Level III ☐ Level IV ☐

Neonatal Program Manager:

Title:

Phone number(s):

Email:

Neonatal Medical Director:

Phone number(s):

Email:

Name of Facility CEO/President:

Title:

Phone number(s):

Email:



Neonatal Statistical Data:

Reporting year:

(Use reporting period provided to survey organization)

Level II (Special Care Nursery)

Total live births for reporting period:

Total Well Nursery (or Mother-Baby) admissions for reporting period:

Total number of Well Nursery beds:

Total Special Care Nursery admissions for reporting period:

Total number of SCN beds:

Average daily census of SCN beds:

Total live births ≤ 32 weeks and birth weight ≤ 1500 grams admitted:

Total neonates on assisted endotracheal ventilation > 24 hours or
NCPAP until condition improved:

Total neonates/infants transferred in:

- Total neonates received following delivery outside of hospital:
- Total neonates transferred in from another hospital:

Total neonates/infants transferred out:

Total multiple births:

Total neonatal deaths:

Level III (Neonatal Intensive Care Unit) or Level IV (Advanced Neonatal ICU)

Total live births for reporting period:

Total Well Nursery (or Mother-Baby) admissions for reporting period:

Total number of Well Nursery beds:

Total Special Care Nursery admissions for reporting period:



Total number of Special Care Nursery beds:	<input type="text"/>
Average daily census of SCN beds:	<input type="text"/>
Total NICU/Advanced NICU admissions for reporting period:	<input type="text"/>
Total number of NICU beds:	<input type="text"/>
Average daily census of NICU beds:	<input type="text"/>
Total number of Advanced NICU beds:	<input type="text"/>
Average daily census of Advanced NICU beds:	<input type="text"/>
Total neonates/infants transferred in:	<input type="text"/>
• Total neonates received following delivery outside of hospital:	<input type="text"/>
• Total neonates transferred in from another hospital:	<input type="text"/>
Total neonates/infants transferred out:	<input type="text"/>
Total multiple births:	<input type="text"/>
Total neonatal deaths:	<input type="text"/>
Total number of NICU patient surgical events:	<input type="text"/>
• Total OR number:	<input type="text"/>
• Total bedside number:	<input type="text"/>

Signature of Neonatal Program Manager

Date

Signature of Neonatal Medical Director

Date

Signature of CEO/President

Date