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Hospital Name Change Request

Please complete the following form to request a hospital name change in the Georgia Office of EMS and Trauma License Management System and other EMS systems.

Complete and scan the form to a PDF file format and email it to <u>dph-phemsinfo@dph.ga.gov</u>.

Current DPH Designation(s) (if applicable):

Stroke Center	Cardiac Center	Trauma Center	Other:	
	FACI	LITY DEMOGRAPHICS		
Existing/Previous Fa	acility Name:			
New Facility Name:				
Facility Address:				
Effective Date of Na	me Change:			
	REQU	ESTOR INFORMATION		
Name:				
First N		Middle Initial		Last Name
Title:			_	
Contact Number:	Em	ail Address:		
		SIGNATURE		
I understand and have the opportunity to ask	-	sequences of signing th	iis document ar	id have been given

Printed Name

Signature

Date Signed

Form REV 5/26/2022

We protect lives.