NORTH CAROLINA TRAUMA CENTER SITE VISIT REPORT FORM

Hospital Facility: _____

Location: _____

Date of visit: _____

Name of site team reviewer: _____

Designation level (I, II or III): _____

(1) Center's notable strengths:

(2) Significant deficiencies (i.e., the failure to meet state criteria):

(3) Weaknesses (i.e., state criteria met at a minimum):

(4) Specific comments regarding dedication to trauma system concepts (for the areas of continuing education, outreach programs, research and quality assurance):

(5) Summary of Medical Chart Review Findings:

(6) Recommendations:

(7) Other Comments:

_____ _____

Signature Date

NOTE: Email a copy of your typed medical chart reviews and this completed form to the primary reviewer within 7 days of the site visit. Mail your signed original of the typed medical chart reviews to Ms. Nadine Pfeiffer at:

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