



Registration and Inventory of Medical Equipment
Cardiac Catheterization Equipment
January 2015

Instructions

This is the legally required “Registration and Inventory of Medical Equipment” (G.S. 131E-177) for cardiac catheterization equipment. Please complete all sections of this form and return to the Medical Facilities Planning Branch by **Friday, January 30, 2015**.

1. Complete and sign the form
2. Return the form by one of two methods:
 - a. Email a scanned copy to DHSR.SMFP.Registration-Inventory@dhhs.nc.gov
 - b. Mail the form to Kelli Fisk, Medical Facilities Planning Branch, 2714 Mail Service Center, Raleigh, NC 27699-2714.

Note: Fixed equipment operated in a facility licensed under a hospital should be reported on that hospital’s license renewal application, and not duplicated on this form.

If you have questions, call Kelli Fisk in the Medical Facilities Planning Branch at (919) 855-3865 or email DHSR.SMFP.Registration-Inventory@dhhs.nc.gov.

Section 1: Contact Information

1. Full legal name of corporation, partnership, individual, or other legal entity that acquired the equipment by purchase, donation, lease, transfer, or comparable arrangement:

(Legal Name)

2. Address of the corporation, partnership, individual, or other legal entity that acquired the equipment:

(Street and Number)

_____ (_____) _____

(City) (State) (Zip) (Phone Number)

3. Chief Executive Officer or approved designee who is certifying the information in this registration form:

_____ (Name) _____ (Title)

_____ (Street and Number) _____ (City) _____ (State) (Zip)

(_____) _____ (_____) _____

(Phone Number) (Email)

4. Information Compiled or Prepared by: _____ (Name)

(_____) _____ (_____) _____

(Phone Number) (Email)



Section 2: Equipment and Procedures Information

Time Period for Report: 10/01/2013 – 9/30/2014 Other time period: _____

(Please make additional copies of pages of this form as needed.)

Cardiac Catheterization Equipment (one piece of equipment per page)		
Fixed or Mobile* Equipment?	(check one) Fixed: <input type="checkbox"/> Mobile: <input type="checkbox"/>	
Manufacturer		
Model Number		
Serial or I.D. Number		
Certificate of Need Project ID		
Certificate Holder, as listed on Certificate of Need		
Service Site _____		
Address _____		
City, State, Zip _____ County _____		
Procedures (defined to be one visit or trip by a patient to a catheterization laboratory for a single or multiple catheterizations. Count each visit once, regardless of the number of diagnostic, interventional, electrophysiology and angiography catheterizations performed within that visit.)	Diagnostic Cardiac Catheterization Procedures ICD-9: 37.21, 37.22, 37.23, 37.25	Interventional Cardiac Catheterization Procedures ICD-9: 00.66, 99.10, 36.06, 36.07, 36.09; 35.52, 35.71, 35.96
Number of Procedures Performed in Fixed Units on Patients Age 14 and younger		
Number of Procedures Performed in Fixed Units on Patients Age 15 and older		
	Electrophysiology Procedures ICD-9: 37.26, 37.27, 37.34, 37.70, 37.71, 37.72, 37.73, 37.74, 37.75, 37.76, 37.77, 37.79, 37.80, 37.81, 37.82, 37.83, 37.85, 37.86, 37.87, 37.89, 37.94, 37.95, 37.96, 37.97, 37.98, 37.99, 00.50, 00.51, 00.52, 00.53, 00.54	
Number of Procedures on Dedicated EP Equipment		
Number of Mobile Procedures		
Put a check by the days per week, and write in the number of hours per day, the equipment is in operation.	___ Sun: ___ hours ___ Mon: ___ hours ___ Tue: ___ hours ___ Wed: ___ hours ___ Thu: ___ hours ___ Fri: ___ hours ___ Sat: ___ hours	
Total number of hours in operation during report period		
Number of 8-hour days per week the mobile unit is onsite: _____ 8-hour days per week. (Examples: Monday through Friday for 8-hours per day is 5 8-hour days per week. Monday, Wednesday, & Friday for 4 hours per day is 1.5 8-hour days per week)		

* Mobile Equipment means cardiac catheterization equipment and transporting equipment which is moved to provide services at two or more host facilities.

Name of entity that acquired the equipment (from page 1) _____



Section 3: Certification and Signature

The undersigned Chief Executive Officer or approved designee certifies the accuracy of the information contained on all pages of this form.

Signature _____

Print Name _____

Date signed _____

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