

MEMBERSHIP APPLICATION & REGISTRATION FORM

RAC-R FYE 2021 (09/01/20 – 08/31/21)

Name of organization

Name of CEO or Chief

Physical address

Mailing address

Office #

Fax #

Employer ID Number (EIN)
(Example: 74-1234567)

EMS/TRAUMA REPRESENTATIVE TO THE RAC

Name

Title/Position

E-mail

Mobile #

EMS/TRAUMA ALTERNATE REPRESENTATIVE TO THE RAC

Name

Title/Position

E-mail

Mobile #

EMERGENCY CONTACT FOR ORGANIZATION

Name

Title/Position

E-mail

Office

Mobile

Fax

OTHER REPRESENTATIVES	
Neonatal Representative	Maternal Representative Name
E-mail	E-mail
Phone	Phone
Acute Care Representative	
E-mail	
Phone	
Printed Name of person authorized to commit the organization to membership in the RAC	
Signature	
Date	

Membership Application/Renewal Process RAC-R FYE 2021 (09/01/20 – 08/31/21)

<input type="checkbox"/>	1. Complete Membership Application and Registration Form
<input type="checkbox"/>	2. Read Membership SOPs and By-Laws (<i>available at www.rac-r.com</i>)
<input type="checkbox"/>	3. Read and sign Member Responsibility Review
<input type="checkbox"/>	4. Pay dues
<input type="checkbox"/>	5. Read and sign Trauma Systems Plan
<input type="checkbox"/>	6. Read and sign Regional Stroke Plan
<input type="checkbox"/>	7. Complete Gap Analysis as applicable per service/facility
<input type="checkbox"/>	8. (EMS only) Complete Affidavit Acknowledging Utilization of RAC Regional Protocols Regarding Patient Destination and Transport and the Adult Trauma Pre-Hospital Triage Guidelines. (two pages to sign)

Return all documents to:

East Texas Gulf Coast Regional Trauma Advisory Council

PO Box 1015

Manvel, TX 77578-1015

Phone: (281) 519-8780

Fax: (281) 489-0024

racinfo@bcesd3.com

*(Please send all forms by regular US Mail or by e-mail. It is **not** necessary to send them by certified mail.)*



INVOICE

East Texas Gulf Coast Regional Trauma Advisory Council

INVOICE # M2020
DATE: , 2020

PO Box 1015, Manvel, Texas 77578
Phone 281-519-8780 Fax 281-489-0024
racinfo@manvelems.org
www.rac-r.com

TO

Dues for Membership in RAC-R for Fiscal Year 2020-2021 due to COVID -19 are listed in **RED**.

Please check one:

- | | |
|---|---------------------------|
| <input type="checkbox"/> EMS 1 - 3 licensed ambulances | \$150 - \$75 |
| <input type="checkbox"/> EMS 4 - 6 licensed ambulances | \$250 - \$125 |
| <input type="checkbox"/> EMS 7 - 10 licensed ambulances | \$500 - \$250 |
| <input type="checkbox"/> EMS > 10 licensed ambulances | \$750 - \$375 |
| <input type="checkbox"/> First Responder Organization | \$100 - \$50 |
| <input type="checkbox"/> Air Medical Provider (Fixed Wing or Rotor) | \$500 - \$250 |
| <input type="checkbox"/> Hospital Non-designated Trauma | \$500 - \$250 |
| <input type="checkbox"/> Hospital Level IV Trauma | \$600 - \$300 |
| <input type="checkbox"/> Hospital Level III Trauma | \$750 - \$375 |
| <input type="checkbox"/> Hospital Level II & I Trauma | \$1250 - \$625 |

Make all checks payable to:
East Texas Gulf Coast Regional Trauma Advisory Council

**Due no later than November 13, 2020. thank you for your
PARTICIPATION!**



Member Responsibility Review RAC-R FYE 2021 (9/1/20 - 8/31/21)

1. Each member representative or alternate must attend at least **75%** of the scheduled General Assembly Meetings for fiscal year 2020-2021.
2. Each member representative or alternate must attend at least **75%** of the committee meetings of each committee where the member provides related services. Any staff member may represent the service or hospital at a committee meeting.
3. Each member must submit stroke/stemi data to the RAC on a *monthly* basis.
4. Each member must submit a new Membership Application & Registration Form and provide a phone number or numbers at which they and their designated staff as well as their Medical Director or Emergency Manager can be contacted at anytime during a declared emergency.
5. Each member acknowledges that they have read the membership SOPs and By-Laws of the RAC.
6. Each member will complete and submit an annual needs assessment with the membership packet.
7. Each EMS member must complete and submit a Protocol Affidavit, Adult Pre-Hospital Triage Form and Trauma Systems Plan signature page completed by the Medical Director for the service prior to the **August 31, 2020** deadline.
8. Each Hospital must complete and submit the Medical Director Signature page from the Trauma System plan indicating they have read and understand the plan prior to the **August 31, 2020** deadline.
9. Each member must pay membership dues. Checks must be made payable to: *East Texas Gulf Coast Regional Trauma Advisory Council and must be received on or before **November 13, 2020** to maintain eligibility requirements.*
10. Each member understands that failure to complete all aspects of the membership process to include annual submission of all documentation described above, attendance requirements as described above and submission of data as requested above will place their agency/facility in jeopardy of receiving funding, equipment, services, and or any other benefits of membership.

I have read the RAC Responsibility Review Form and understand the requirements for maintaining RAC membership. I understand all paper documentation is due to the RAC office on or before **August 31, 2020**. All packets or incomplete packets received after **August 31, 2020** will result in loss of credit for participation for the September 2020 General Assembly and Committee Meetings.

Membership dues must be received by the RAC office on or before **November 13, 2020**. Membership dues received by the RAC office after the deadline will result in loss of participation for the December 2020 General Assembly and Committee Meetings.

RAC Representative Signature

Date

Printed Name

Organization

**Affidavit Acknowledging Utilization of RAC Regional Guidelines
Regarding Patient Destination and Transport**

Provider: _____
License #: _____ This Affidavit Submitted for FYE 2021
County of Licensure: _____ Level of Service: _____
Counties of Operation: _____

To be eligible for funding from the EMS/Trauma Care System Account, an EMS provider must, as specified in EMS rule § 157.130 (e)(1)(B)(iii), “demonstrate utilization of the Regional Advisory Council (RAC) regional guidelines regarding patient destination and transport in all TSAs in which they operate”.

As the Administrator and Medical Director for _____
(Licensed Provider Name)

we acknowledge this provider’s utilization of the pre-hospital triage and bypass guidelines as approved by the Bureau of Emergency Management of the Texas Department of Health and adopted by the RAC for Trauma Service Area (TSA) R.
(Note a separate affidavit is required for each TSA in which you operate)

We understand that incorporation of the RAC pre-hospital triage and bypass guidelines into our EMS provider’s medical guidelines and/or standard operating procedures and utilization of these guidelines by field medical personnel are required actions to meet the terms of utilization.

Furthermore, we understand that this signed document may be subject to future evaluation for compliance with the requirements of § 157.130.

Administrator (Printed Name)

Medical Director (Printed Name)

Administrator (Signature)

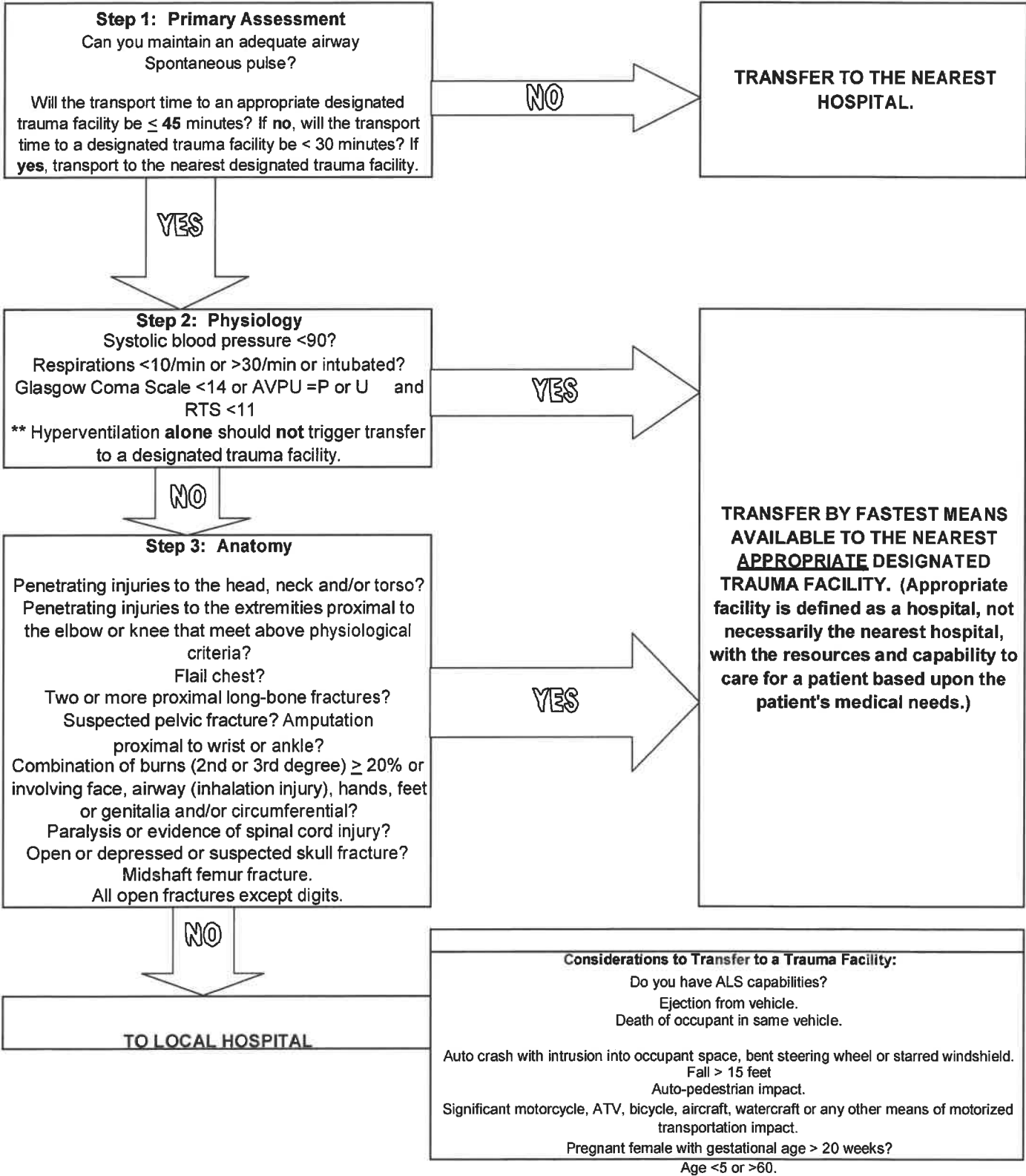
Medical Director (Signature)

Date

Date

Please Note: The address of the RAC Office is: East Texas Gulf Coast Regional Trauma Advisory Council, PO Box 1015, Manvel, Texas 77578.

East Texas Gulf Coast Regional Trauma Advisory Council Adult Trauma Pre-Hospital Triage Guidelines



Medical Director _____

Date _____

APPENDIX A

East Texas Gulf Coast Regional Trauma Advisory Council REGIONAL TRAUMA SYSTEM PLAN Signature Page

I have read and reviewed the East Texas Gulf Coast Regional Trauma System Plan. I understand this is a regional and overarching plan and may not reflect the practice of my institution.

Approval of Trauma Medical Directors, EMS Directors and EMS Administrators:

Facility / Service

Name of the Trauma Medical Director
or EMS Medical Director

Name of EMS Administrator

Signature of the Trauma Medical Director
or EMS Medical Director

EMS Administrator Signature

Date

ACKNOWLEDGEMENT
East Texas Gulf Coast Regional Trauma Advisory Council
REGIONAL STROKE PLAN
Signature Page

Approval of Medical Directors and EMS Directors

Facility / Service

Name of the Stroke Coordinator or EMS Director

Medical Director or EMS Director Signature

Date



East Texas Gulf Coast Regional Trauma Advisory Council

ANNUAL PREHOSPITAL GAP ANALYSIS

FY 2021 (09/01/20-08/31/21)

As a requirement for membership, EMS/Fire agencies must complete a gap analysis. Complete the following document related to providing prehospital care at your agency. Thank you for your assistance.

Facility Name			
Name of Person Completing Form			Are you the RAC Representative? Yes No
Contact Information	Email:		Phone:
Are you the Chief/Director?	Yes	No	If 'No', what is your role?
Does your agency partner with any FROs?	Yes	No	If 'Yes', what agencies?
Does your agency operate a CE program?	Yes	No	If 'Yes', is it open to individuals outside of your agency?

In order for TSA-R to assist you it is important for us to understand the needs of your agency. Below is a list of areas pertaining to providing care in a prehospital setting. Review the list and provide feedback listing the strengths and gaps at your agency.

	Agency Strengths	Agency Gaps
Emergency Preparedness		
CE/Training		
Cardiac/STEMI		
Neonate/Pediatrics		
Sepsis		
Stroke		
Trauma		
Injury Prevention/Outreach		



East Texas Gulf Coast Regional Trauma Advisory Council
ANNUAL PREHOSPITAL GAP ANALYSIS

FY 2021 (09/01/20-08/31/21)

	Agency Strengths	Agency Gaps
Data Collection Trauma Registry		
Performance Improvement		

Based on the gaps you listed, please provide feedback on how TSA-R can assist you to close these gaps.

What programs have you instituted at your facility that would be beneficial to other agencies/facilities in RAC-R?

What topics would you like presented at the quarterly RAC-R Prehospital Committee meetings?



East Texas Gulf Coast Regional Trauma Advisory Council ANNUAL HOSPITAL TRAUMA GAP ANALYSIS

FY 2021 (09/01/20-08/31/21)

As a requirement for membership, facilities must complete a gap analysis of your trauma program. Complete the following document related to Trauma at your facility. Thank you for your assistance.

Facility Name						
Name of Person Completing Form				Are you the RAC Representative?	Yes	No
Contact Information	Email:			Phone:		
Are you the Trauma Program Manager?	Yes	No	If 'No', what is your role?			
Has your facility received trauma designation by DSHS?	Yes	No	Circle Trauma Level: I II III advanced III IV			
If your facility has not undergone DSHS designation, are you in active pursuit of designation?	Yes	No	NA	If 'Yes', when do you anticipate undergoing initial trauma designation? List Year.		

The American College of Surgeons Committee on Trauma believes “individual trauma centers must be effectively engaged in all aspects of trauma system planning, implementation and evaluation.” In order for TSA-R to assist you it is important for us to understand the gaps in trauma care at your facility.

<https://www.facs.org/-/media/files/quality%20programs/trauma/vrc%20resources/resources%20for%20optimal%20care.aspx>

Below is a list of items required for trauma designation which may differ based on trauma level designation. Review the list and provide feedback listing the strengths and gaps at your facility

	Facility Strengths	Facility Gaps
Prehospital Care		
Emergency Department Care		
Interfacility Transfer		
Definitive Care		
Interfacility Transport		
Trauma Critical Care		



East Texas Gulf Coast Regional Trauma Advisory Council
ANNUAL HOSPITAL TRAUMA GAP ANALYSIS

FY 2021 (09/01/20-08/31/21)

Rehabilitation		
Injury Prevention		
Data Collection- Trauma Registry		
Performance Improvement		
Staff Education		

Based on the gaps you listed, please provide feedback on how TSA-R can assist you from a trauma system standpoint to close these gaps.

What programs have you instituted at your facility that would be beneficial to other facilities in RAC-R?

What topics would you like presented at the quarterly RAC-R Trauma Committee meeting?

East Texas Gulf Coast Regional Trauma Advisory Council

Perinatal Needs Assessment

FYE 2021 (09/01/20-08/31/21)

Agency

Name: _____

Date Completed: ____ / ____ / ____

1. Annual number of deliveries per year? _____
2. Anticipated Maternal Level of Care? _____
3. Number of LDR/LDRP Beds? _____
4. Number of PP/MBU Beds? _____
5. Maternal Transport Service? _____
6. Maternal Transfers – In _____ Out _____
7. Designated Neonatal Level of Care? _____
8. Annual NICU admits _____
9. Number of NICU Beds _____
10. Neonatal transfers – In _____ Out _____
11. Does your facility offer educational programs? Y or N
 - a. Please supply us with the number of instructors for each educational program
 - i. NRP _____
 - ii. STABLE _____
 - iii. Intermediate/Advanced Fetal Monitoring _____
 - iv. Car Seat Inspector _____
 - v. Other Perinatal Courses _____

If you have needs, please fill out the tables below.

Equipment Needs

Equipment	#1 Priority	#2 Priority	#3 Priority	Do you have plans to meet these needs	Matching funds available Y/N

Educational Needs

Course needed	Training Equipment Needed	# Students Needing Initial Training	# Students Renewing	Do you have plans to meet these needs	Matching funds available Y/N

Maternal Program Manager Name and email?

Neonatal Program Manager Name and email?

Who completed this form?

Print: _____

Sign: _____

TSA "R" Member Signature:
