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| **DEPARTMENT OF HEALTH SERVICES**  Division of Public Health  F-00602B (01/2023) | | | **STATE OF WISCONSIN** | | |
| **TRAUMA CARE FACILITY**  **PAPERWORK SUBMISSION FOCUSED VISIT COVER SHEET** | | | | | |
| **Facility Name** | | **Requested Level** | | **Date of Submission** | **Date of Original Review** |
|  | |  | |  |  |
| **Criterion Deficiency with Corrective Action** (with attached documentation)  Criteria Deficiency:  Corrective Action:  Documentation attached?  Yes  No  If yes, please supply the name of the document | | | | | |
| **Criterion Deficiency with Corrective Action** (with attached documentation)  Criteria Deficiency:  Corrective Action:  Documentation attached?  Yes  No  If yes, please supply the name of the document | | | | | |
| **Criterion Deficiency with Corrective Action** (with attached documentation)  Criteria Deficiency:  Corrective Action:  Documentation attached?  Yes  No  If yes, please supply the name of the document | | | | | |
| **Additional Facility Comments** | | | | | |
|  | | | | | |
| **Reviewer Comments** *(For DHS use only)* | | | | | |
| **Facility Signature** | TPM:  TMD:  Administrator: | | | | |
|  | | | | |
| **Site Reviewer Signature** *(For DHS use only)* |  | | | | |
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