M·TQIP

MQIP Application Form

Facility Information

Hospital Name:
Address (line 1):
Address (line 2):
City:
State:
Zip Code:
ACS COT Accreditation: ☐ I ☐ II ☐ III

Facility Contacts

Trauma Director Name (or equivalent):
Title:
Email:
Phone:
Fax:

Surgeon Champion Name (if different from above):
Title:
Email:
Phone:
Fax:

Trauma Program Manager Name:
Title:
Email:
Phone:
Fax:

Trauma Registrar Name:
Title:
Email:
Phone:
Fax:

Primary Contact Name:
Address:
City:
State:

Zip:

Request

- ☐ Request for information only
- ☐ Request for membership
- ☐ Other:

Submit application via email to jmikhail@med.umich.edu