Registration and Inventory of Medical Equipment
Cardiac Catheterization Equipment
January 2011

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 Registration and Inventory Form and return by **5:00 p.m. on Monday, February 14, 2011**. We encourage you to email the completed and signed form in a Portable Document Format (pdf) file to DHSR.SMFP.Registration-Inventory@dhhs.nc.gov. If it is not possible to email the completed form, you can mail it to Kelli Fisk, Medical Facilities Planning Section, 2714 Mail Service Center, Raleigh, NC 27699-2714. If you have questions, you can send an email to DHSR.SMFP.Registration-Inventory@dhhs.nc.gov or call the Medical Facilities Planning Section at (919) 855-3865. Thank you!

Section One 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 who is certifying the information in this registration form:

   _____
   (Name) (Title)

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

   (_____) _____ _____
   (Phone) (Email)

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

   Phone (_____) _____ E-mail _____

Section Two Equipment and Procedures Information

Time Period for Report: ❑ 10/01/2009 – 9/30/2010 ❑ 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: ❑	Mobile: ❑	
Manufacturer			
Model #			
Serial or I.D. #			
Certificate of Need Project ID			
Certificate Holder, as listed on Certificate of Need			
Name of entity where service is provided (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, and/or EP 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	Electro-physiology 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 Fixed Procedures on Patients Age 14 and younger			
Number of Fixed Procedures on Patients Age 15 and older			
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 # 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.

Section Three **Certification and Signature**

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

Signature _____

Print Name _____

Date signed _____

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

Please return the completed form by 5:00 p.m. Monday, February 14, 2011 by email to DHSR.SMFP.Registration-Inventory@dhhs.nc.gov (pdf file), or mail to Kelli Fisk, Medical Facilities Planning Section, 2714 Mail Service Center, Raleigh, NC 27699-2714. If you have questions, send an email to DHSR.SMFP.Registration-Inventory@dhhs.nc.gov or call (919) 855-3865.

Thank you!