ESRD Network 12

FACILITY CARE TEAM ACKNOWLEDGEMENT FORM
Long Term Catheter Reduction - Quality Improvement Project

Facility Name_____**CCN**_____

1.) **MEDICAL DIRECTOR ACCOUNTABILITY:** The Medical Director must sign to acknowledge his/her support for the facility's participation in this Network-sponsored quality improvement project.

Medical Director Signature: _____

Email Address: _____

2.) **CARE TEAM ACCOUNTABILITY:** To acknowledge that critical team members are aware of this Network quality improvement project.

Please print/type name and then have team member initial.

Administrator:	Initial:
Nurse Manager:	Initial:
Other:	Initial:

3.) **FACILITY CONTACT PERSON, CROWNWeb User(s), & PATIENT REPRESENTATIVE:** Please list the name of the staff person at your facility who will be the Project Coordinator, CROWNWeb User, Regional/ Corporate Lead, and a patient who will serve as the Patient Representative:

PROJECT COORDINATOR	PHONE	EMAIL
CROWNWeb User	**PHONE**	**EMAIL**
REGIONAL/CORPORATE LEAD	**PHONE**	**EMAIL**
PATIENT REPRESENTATIVE	**PHONE**	**EMAIL**

NETWORK PROJECT LEAD	PHONE	EMAIL
Sharlyn Bogner	816-880-1706	sbogner@nw12.esrd.net

Please complete and return this document via fax to 816-880-9088 by: February 28, 2017