Accreditation Association for Podiatric Surgical Facilities
193 W. Paddock Circle
Arnold, Maryland 21012
410-647-5210

## APPLICATION FOR ACCREDITATION AND PRESURVEY QUESTIONNAIRE

Prior to completing the accreditation survey application, a review of the standards is recommended. Facilities seeking accreditation should comply with all standards before the application is submitted (including those related to emergency medications and equipment).

All completed applications should be returned electronically via email to info@aapsf.com

Legal Name of Organization: ____________________________________________

DBA (if applicable): ____________________________________________________

Street Address: _______________________________________________________

City: ______________________________ State: ___________ Zip: ___________

Office Telephone: ____________________ Office Fax: ______________________

Medical Director: _____________________________________________________

Survey Contact Person: ________________________________________________

Survey Contact Telephone: ____________________ Email: ___________________

If your podiatric surgical facility is a subunit of a larger organization, or if it is owned, operated or managed by, or affiliated with another organization, indicate the name and address of the organization.

_________________________________________________________________

Chief Executive Officer: _______________________________________________

The undersigned makes application to AAPSF for an accreditation survey of the above named organization, certifies the organization meets the survey eligibility criteria, and grants permission to the state licensing agency or any other relevant examining or reviewing agency to release official records of the organization to AAPSF if necessary for its consideration concerning accreditation.

Medical Director: _____________________________________________________
Signature

Name: ________________________________ Date: _______________________

List all providers utilizing the facility. Provide a letter of current hospital privileges for each.

Name: ________________________________ Specialty: ____________________

Name: ________________________________ Specialty: ____________________

Name: ________________________________ Specialty: ____________________

Name: ____________________________________ Specialty: ________________________

Name: ____________________________________ Specialty: ________________________

Do all medical staff have current malpractice coverage? YES NO

Date facility began operation: __________________________________________________

Is the organization licensed by the state in which the facility is located? YES NO
(Attach copy of current license)

Is the organization Medicare certified as an ambulatory surgery center? YES NO
(Attach copy of CMS approval letter and provide date of last survey)

Does the facility have a current CLIA to perform in-house laboratory procedures? YES NO

Are radiology services provided by the facility? YES NO

Date radiology equipment was last inspected by the appropriate health authority __________

Does the facility refer radiological procedures to an outside radiology service? YES NO

Does the facility provide for the administration of anesthesia? (Check all that apply)
☐ Local ☐ Nitrous Oxide ☐ IV Sedation ☐ General ☐ Other ___________

List the name, title and type of anesthesia administered for each provider of anesthesia services in the facility.

| NAME | DPM/MD CRNA | LOCAL | NITROUS OXIDE | IV SEDATION | GENERAL | OTHER |
|---|---|---|---|---|---|---|
| | | | | | | |
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| | | | | | | |

List the approximate number of the following types of podiatric procedures performed in the facility in the past year.
Soft Tissue: _______________ Osseous: ___________________

What is the average number of podiatric procedures performed per month? ______________

How many surgical suites are located within the facility? ____________________________

What is the approximate size of each surgical suite? _________________________________

What is the square footage of the facility? ________________________________________

List the name and location of the hospital used by the facility if an emergency admission is necessary? ____________________________________________________________

What is the distance of the above-named hospital from the facility? ____________________

Is there a policy for handling medical emergencies? YES NO

What type of emergency power is available in the surgical suite (OR, PACU, etc.)?

___________________________________________________________________________

Is there an on-call system for after hours and weekend care? YES NO
If yes, specify ______________________________________________________________

Are the facility's medical records on paper or EMR? ________________________________

Does the facility teach or train students on-site? YES NO
If yes, what types of students are trained? _____________________________________

Is research conducted at the facility? YES NO
If yes, specify ______________________________________________________________

List the number of non-physician health care providers employed by the facility.

_____ Nurse Practitioner

_____ Registered Nurse

_____ Licensed Practical Nurse

_____ Physician Assistant

_____ OR Technician

_____ Medical Assistant

_____ Medical Technologist

_____ Radiology Technologist

Is there a formal orientation program for new employees? YES NO

Are staff trained in CPR available in the facility whenever patients are being treated?
YES NO

How many of the facility staff are currently CPR certified? _________________________

Is there an ACLS certified provider available any time anesthesia other than local is provided?
YES NO

Is there an appropriately stocked crash cart? YES NO

Is there a signed document indicating the facility anesthesia provider has concurred with the recommended medication list and has no recommendations for additional emergency medications

Is there a signed document indicating the facility anesthesia provider has concurred with the recommended emergency equipment list and has no recommendations for additional emergency equipment

List any additional comments you feel will assist the surveyor(s) in the evaluation of the facility.

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________