Cardiac Conditions in Obstetrical Care

Enrollment Form

GaPQC
GEORGIA PERINATAL QUALITY COLLABORATIVE

Hospital Name*

Indicate your level of participation :

☐ **Learning Collaborative**
Please provide your contact information

Name	Email	Phone	Credentials

☐ **Active Improvement Team**
Please complete the rest of the form

Initative Champions	Name	Email	Include on GaPQC Emails	Phone	Credentials
Physician or Advance Practice Provider Champion			☐		
Project Champion			☐		
Data Lead			☐		

Additional Multidisciplinary Champions

Specialty (e.g. Cardiology, Emergency Medicine, Anesthesiology, Labor and Delivery, etc.)	Name	Email	Include on GaPQC Emails	Phone	Credentials
			☐		
			☐		
			☐		

By signing below, I acknowledge my understanding of the goals and expectations of Georgia Perinatal Quality Collaborative and commit to full participation in the mutually agreed upon initiative(s).

Physician or Advance Practice Provider Champion
Signed: **Date:**
Name:

Project Champion
Signed: **Date:**
Name:

*Please check this box if you would like to join the Learning Collaborative as an individual and not as a representative of a hospital ☐

Email your completed enrollment form to:

Lisa Ehle
Maternal Quality Improvement
Lisa.Ehle@dph.ga.gov