|  |
| --- |
| **GaPQC Lead Coordinator** |
| Hospital |  |
| Name/Title |  |
| Phone |  |
| Email |  |
|  |  |
| **Core Components** (Required to participate) | **Y** | **N** |
| Is your hospital willing to participate in a baseline hospital survey? |  |  |
| Is your hospital willing to submit data to DPH for GaPQC Initiatives? |  |  |
| Which initiative are you enrolling in? □ Obstetric Hemorrhage □ Severe Hypertension in Pregnancy |
|  |  |  |
| **Core Team Members** | **Name** | **Email** | **Phone** |
| Physician Champion\* |  |  |  |
| Nurse Champion\* |  |  |  |
| QI Champion |  |  |  |
| Data Champion |  |  |  |
| Executive Champion |  |  |  |

\*Recommended at minimum

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 Champion**

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: Click here to enter text.
Name: Click here to enter text. Date: Click here to enter a date.

**Nurse Champion**

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: Click here to enter text.
Name: Click here to enter text. Date: Click here to enter a date.

**Email your signed Enrollment Form to:**Diane Durrence
Women’s Health Director
diane.durrence@dph.ga.gov