|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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](mailto:diane.durrence@dph.ga.gov)