

Optimizing Nutrition for Georgia Newborns Enrollment Form



Hospital Name*

Hospital Address

Indicate your level of participation :

Learning Collaborative
Please provide your contact information

Name	Email	Phone	Credentials
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Active Improvement Team
Please complete the rest of the form

Please indicate a setting. If your hospital is participating in both settings, please complete an enrollment form for each one.

Mother/Baby

NICU

Initiative Champions	Name	Email	Phone	Credentials
Physician or Advance Practice Provider Champion	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Project Champion	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Senior Leader	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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:

Kimberly Ross
Senior Manager
Neonatal Quality Improvement
Kimberly.Ross@dph.ga.gov