STEMI RECEIVING CENTER APPLICATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES
EMERGENCY MEDICAL SYSTEMS UNIT
CARDIAC SYSTEM OF CARE
SFN 62700 (02/2026)

1. Complete all required fields.
2. Dates must reflect the current certification cycle.
3. Ensure the form is signed by a duly authorized agent of the facility.
4. Submit the completed application and all required documents to the contact listed below.

Designation requires participation in the state cardiac registry and sharing of required registry data with the department.

Section 1: Application Information

For purposes of this application, "certification" refers to accreditation by a North Dakota approved cardiac certifying body, which supports state STEMI Receiving Center designation.

Date of Application (MM/DD/YYYY):	Type of Application: (check one) ☐ Initial Designation ☐ Redesignation
Date of Survey (MM/DD/YYYY):	Expiration Date of Certification:

Cardiac Certification Program (check one):

American College of Cardiology (ACC)
- ☐ Chest Pain Center with Primary PCI
- ☐ Chest Pain Center with Primary PCI & Resuscitation

Accreditation for Cardiovascular Excellence (ACE)
- ☐ Cath/PCI

American Heart Association/The Joint Commission
- ☐ Primary Heart Attack Center
- ☐ Comprehensive Cardiac Center

DNV Chest Pain Program Certification (CPP)
- ☐ STEMI Receiving Program/PCI Capable

Other
- ☐ Other Certification (Contact cgreff@nd.gov before selecting this option)

If this is a re-designation, please list the dates of certification below:

From (MM/DD/YYYY):	To (MM/DD/YYYY):	Explanation for lapses in certification (if applicable):

Section 2: Facility Information

Complete all fields.

Official Name of Hospital:			Facility ID Number:
Chief Executive Officer or Administrator Name:			
Mailing Address:	City:	State:	ZIP Code:
County:	Telephone Number and Extension:		

Section 3: Facility Contact Person

Name:	Title / Position:
Email:	Telephone Number and Extension:

Section 4: Duly Authorized Agent

Applications signed by individuals without signatory authority will be returned.

Name:	Title / Position:
Email:	Telephone Number and Extension:

Section 5: Certification of Information

The duly authorized agent of the hospital must sign the following certification:

I certify that the information contained in this application and all attached materials is true, accurate, and complete to the best of my knowledge.

I further certify that our hospital participates in the state cardiac registry, including through data bridging if applicable, and agrees to share registry data with the department's designated superuser account in accordance with North Dakota Century Code chapter 23-47 for purposes of system oversight, quality improvement, and reporting.

Attached to this application is a copy of the letter of certification from a North Dakota-approved Cardiac Certification Program for STEMI Receiving Center Designation, and a copy of the entire survey from the accrediting body.

Signature of Duly Authorized Agent:	Date (MM/DD/YYYY):
Printed Name:	Title / Position:

Section 6: Certification Checklist – Submit the following documents with your application:

- Completed and signed application
- Copy of the certification letter
- Copy of the accrediting body survey*

***Survey Submission Alternatives:**

If the facility is unable to submit the full accrediting body survey due to confidentiality or accreditor restrictions, the facility may submit one of the following alternatives, subject to state review and approval:

a. A redacted copy of the accrediting body survey that includes all findings, conditions, and required corrective actions related to STEMI care and system of care requirements; or
b. The accrediting body survey executive summary and corrective action plan (if applicable)

Section 7: Expiration and Renewal Guidance

The STEMI Receiving Center designation remains valid for the duration of the facility's approved certification program. To ensure continuous designation status, facilities must submit updated certification documentation and survey results upon each renewal of certification.

Survey materials are used solely to support designation review and are treated as non-public records to the extent permitted by law.

Submission:
Submit completed forms and all required documents electronically to:
Email: cgreff@nd.gov
Please allow 3 – 5 business days for confirmation of receipt.

Questions and Comments:
North Dakota Cardiac System of Care
Emergency Medical Systems Unit
Email: cgreff@nd.gov
Phone: (701) 328-4577
Website: https://ww.hhs.nd.gov/health/EMS/north-dakota-cardiac-system-care

DEPARTMENT USE ONLY
Certification Number:
Designation Period:
Reviewer Initials:
Approval Date: