|  |  |
| --- | --- |
| **DEPARTMENT OF HEALTH SERVICES**Division of Public HealthF-00602C (01/2023) | **STATE OF WISCONSIN** |
| **TRAUMA CARE FACILITY CLASSIFICATION REVIEW COMMITTEE****FOCUSED VISIT ACTION PLAN REPORT** |
| **Facility Name** | **Requested Level** | **Date of Submission** | **Date of Original Review** |
|       |  |       |       |
| **Criterion Deficiency with Corrective Action**Criteria Deficiency:      Corrective Action:       |
| **Criterion Deficiency with Corrective Action**Criteria Deficiency:      Corrective Action:       |
| **Criterion Deficiency with Corrective Action**Criteria Deficiency:      Corrective Action:       |
| **Additional Comments** |
|       |
| **Trauma Program Manager or Trauma Coordinator Signature** |       |
| **Trauma Medical Director Signature** |       |
| **Administrator Signature** |       |