REQUEST FOR WAIVER OF ADMINISTRATIVE RULE
Trauma Care Services

Under Wis. Admin. Code DHS 118.04(5) the department may grant a waiver of any non−statutory requirement under Wis. Admin. Code ch. DHS 118, upon written request, if the department finds that strict enforcement of the requirement will create an unreasonable hardship for the trauma care facilities or the public in meeting the trauma care service needs of the facilities service area and that waiver of the requirement will not adversely affect the health, safety or welfare of patients or the general public. Return this completed form and necessary attachments via email to dhstrauma@dhs.wisconsin.gov or via USPS to: Waiver Request, WI Trauma Program, 1 W Wilson St., P O Box 2659, Madison, WI 53701-2659.

FACILITY INFORMATION

Facility Name

Facility Address

City	State	ZIP Code	County	RTAC Region

Current Trauma Care Level	Requesting Trauma Care Level at Next Review	Expiration Date
Trauma Program Manager	Trauma Medical Director	Administrator
Type of Request ☐ Variance ☐ Waiver	From (mm/dd/yyyy): To (mm/dd/yyyy):	Administrative Code Requested for Waiver or Variance:

DESCRIPTION OF THE WAIVER OR VARIANCE

Reason for Request

Steps facility will implement to ensure the waiver or variance will not adversely affect health, safety, or welfare of any client for the requested action.

If requesting a variance, describe the specific alternative action proposed.

By submitting this application, you are affirming that all statements you have made in this document are true. You understand that the Trauma Program has the right to determine if a waiver will be granted. The decision of the Trauma Program is final and is not appealable under Wisconsin Admin. Code § DHS 118.04(7).

SIGNATURE – Person Requesting Waiver	Date
Print Name	

Send form via email to:

dhstrauma@dhs.wisconsin.gov

or

Mail to:

WI Trauma Program
1 W Wilson Street
PO Box 2659
Madison, WI, 53701-2659

DHS USE ONLY	
☐ Deny Request	☐ Approve Request – Expiration (mm/dd/yyyy):
Comments	

This approval may be rescinded at any time upon determination by the Department.

SIGNATURE – Section Manager	Date Signed (mm/dd/yyyy)