**Infectious Diseases Society of America**
**Antimicrobial Stewardships Centers of Excellence Program Application**

*This is a sample view of the application. The actual application is an online form and must be submitted using the link posted to the IDSA website. Some items may display differently in the online form. The link is only open during application cycles.*

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**Items noted with an asterisk (*) are required.**

**Part 1: Applicant Information**

**A. Hospital Name***
Full name as it appears on public documents such as an operating license or website.
System/IDN Name (if applicable)

**B. Location***
Street, city, state/country, zip code

**C. Website***
Link to the hospital's public website home or landing page (with hospital name and location).
If part of a system, link to main page for applicant hospital.

**D. Size (licensed beds)***
- ❒ < 100
- ❒ 101 – 300
- ❒ 301 – 499
- ❒ 500 – 699
- ❒ 700 – 1000
- ❒ > 1000

**E. Setting***
- ❒ Urban
- ❒ Rural
- ❒ Suburban
- ❒ Other

**F. Type (check all that apply)***
- ❒ Community
- ❒ Community Teaching
- ❒ Academic/University
- ❒ Government/Military
- ❒ Research
- ❒ Critical Access
- ❒ For-profit
- ❒ Not-for-profit
- ❒ Physician Owned
- ❒ Other

**G. Structure***
- ❒ Single, stand-alone facility; not part of a healthcare system
- ❒ Part of multi-site system with governance at both the system and local levels

- ❒ Part of a multi-site system where each site has decision-making autonomy
- ❒ Matrix system: Some functions centralized at the system level, others are local
- ❒ Other

**H. Patient Populations and Specialty Services (check all that apply)***

- ❒ Adults
- ❒ Pediatrics
- ❒ Inpatient
- ❒ Outpatient
- ❒ Trauma
- ❒ Burn unit
- ❒ Cystic fibrosis
- ❒ Solid organ transplant
- ❒ Bone marrow transplant
- ❒ Other

**I. Billing Contact for Invoices***

- ❒ Name
- ❒ Title
- ❒ Department
- ❒ Email address
- ❒ Phone #

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**Part 2: Antimicrobial Stewardship Program (ASP) Description & Documentation**

**A. Hospital Leadership Commitment**

i. Provide Letter of Attestation* *upload limit 1*

**B. Accountability**

i. **Physician ASP Lead Information***

❒ Check if physician lead is primary contact for application and communications

Physician ASP Lead Name*

Degree(s)/Credentials (check all that apply)* *drop down menu*

Title / Role*

Years of Experience* *drop down menu*

Current IDSA member*

- ❒ Yes (prompt for member ID#)
- ❒ No

Percentage of weekly protected or compensated time for ASP * *drop down menu*

Board Certified in Infectious Disease*

- ❒ Yes
- ❒ No

Completion of targeted education focused on stewardship practices or has additional stewardship expertise besides ID training*

- ❒ Yes: Provide description and/or documentation below
- ❒ No

Description of stewardship targeted education or training (200 words or less)

Supporting documentation *upload limit 3*

Optional: Additional qualification details of physician lead (100 words or less)

ii. **Pharmacist ASP Lead Information***

❒ Check if pharmacist lead is primary contact for application and communications
Pharmacist ASP Lead Name*
Degree(s)/Credentials (check all that apply)* *drop down menu*
Title / Role*
Years of Experience* *drop down menu*
Current IDSA member*

- ❒ Yes (prompt for member ID#)
- ❒ No

Percentage of weekly time dedicated to ASP * *drop down menu*

iii. **Primary Contact***

Is physician or pharmacist ASP lead the primary contact?*

- ❒ Yes
- ❒ No *(if checked, items below are conditional)*
  Primary Contact Name
  Credentials (drop-down)
  Title
  Department
  Email address
  Phone #
  Current IDSA member*
  - ❒ Yes (prompt for member ID#)
  - ❒ No

iv. **Secondary Contact (optional)**

Is physician or pharmacist ASP lead the secondary contact?

- ❒ Yes
- ❒ No *(if checked, items below are conditional)*
  Secondary Contact Name
  Credentials (drop-down)
  Title
  Department
  Email address
  Phone #
  Current IDSA member*

- ❒ Yes (prompt for member ID#)
- ❒ No

**C. Pharmacy Expertise**

i. Training completed by pharmacist lead * (check all that apply)
   - ❒ Antimicrobial Stewardship certificate program
   - ❒ 2-year Post-Graduate ID Residency
   - ❒ Infectious Diseases Fellowship
   - ❒ BCIDP (Board Certified in Infectious Diseases)
   - ❒ None of the above

ii. Certificates or documentation for AS training *upload limit 3*

iii. Optional: Additional qualifications details of pharmacist lead (100 words or less)

**D. Action**

i. Provide AS Policy* *upload limit 1*

ii. Provide three AS guidelines, one of which must be for IV to PO interchange.*
Two additional guidelines for a total of five may be included.

   - Upload IV to PO interchange guideline*
   - Upload guideline 2*
   - Upload guideline 3*
   - Upload guideline 4
   - Upload guideline 5

iii. Supporting documentation of antibiotic stewardship interventions that improve patient outcomes and current DAILY stewardship activities *upload no limit*

iv. Example of ONE major initiative that resulted in program identifying a problem and implementing a solution to improve antimicrobial prescribing within the last 3 years.*
IMPORTANT: Example should link CDC AS core elements of action, tracking, reporting, and education, and include supporting documentation with graphs or tables. (500 words or less)

Supporting documentation* *upload no limit*

v. Optional Information (not required for designation)

Describe three to five unique or novel ways your stewardship program has improved antibiotic prescribing, antibiotic-associated outcomes, or diagnostic stewardship. (500 words or less).

One example of an antimicrobial stewardship intervention that involves other clinical pharmacists or pharmacy staff in implementation. *upload limit one*

**E. Tracking**

i. AS metrics tracked (check all that apply)*
- ❒ Resistance
- ❒ NHSN SAAR for antimicrobial utilization
- ❒ DDDs
- ❒ Antibiotic starts
- ❒ Acquisition cost
- ❒ Cost per patient admission
- ❒ Cost per patient day
- ❒ Duration of therapy
- ❒ Other
  List other metrics tracked

ii. Evidence of improvement in antimicrobial prescribing within the past three years *upload no limit*

vi. Evidence an intervention where a change in DOT was tracked.* *upload no limit*

iii. Example of ONE stewardship initiative within the last 2 years, including the associated impact on antimicrobial utilization, cost, clinical outcomes, or adverse effects.*
- ❒ Use example submitted in item D-iv
- ❒ Submit a different example
  Text box (500 words or less)
  Upload documentation including graphs or tables *upload no limit*

iv. Optional (not required for designation):
Describe measurement of daily stewardship interventions. (500 words or less)

**F. Reporting**

i. Describe the ASP reporting structure*
(500 words or less)
Optional supporting documentation *upload limit 3*

ii. Evidence as to how hospital shares facility and/or individual prescriber-specific reports on antibiotic use with prescribers and key stakeholders. * *upload no limit*

**G. Education**

i. Examples of education efforts with different healthcare groups within the last 3 years.* *upload no limit*

ii. Evidence of large-scale education to three targeted audiences/groups.

*upload no limit*

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**Part 3: Optional Additional Information**

i. Documentation of involvement in educational efforts regarding antimicrobial usage/stewardship on a national level. *upload no limit*

ii. Stewardship-related publications within the last 2 years (citations only) *250 words or less*

iii. Stewardship collaborations in the last 3 years *250 words or less*

iv. AS regional and national oral or abstract presentations within the last 2 years *upload limit 5*

v. AS-related research grants within the last 2 years *250 words or less*

vi. Novel approaches to AS *250 words or less*

vii. Additional documents to support application *upload limit 5*

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**Part 4: Terms and Conditions**

By signing below, I acknowledge and agree that I am authorized as a representative of the Hospital submitting this application to accept the following terms and conditions, on behalf of the Hospital, for participation in the Antimicrobial Stewardship Centers of Excellence ("Program"):

- Participation and designation by IDSA as an "Antimicrobial Stewardship Center of Excellence" is subject to Hospital's compliance with all applicable laws and IDSA policies, including specifically those policies related to the Program.
- IDSA is the sole owner of all rights, title, and interest in and to IDSA's name and trademarks, including the IDSA "Antimicrobial Stewardship Center of Excellence" designation, for which a limited, revocable, non-assignable license will be granted to Hospital for use, only upon the prior review and approval of IDSA, and subject to the terms and conditions of the Program.
- The Hospital shall pay a non-refundable license fee of five thousand dollars ($5,000.00) with each approved initial or renewal application for participation in the Program.
- The limited license herein and related fee will be valid for two (2) years starting with the date listed on the Program designation letter and certificate provided by IDSA and will expire at the end of the two (2) year period. Hospital's use of the limited license must cease following expiration or termination of Hospital's participation in the Program.
- IDSA will list the Hospital's name on its public website list of Antimicrobial Stewardship Centers of Excellence.
- Neither IDSA nor the Hospital may disclose any Confidential Information of the other that was acquired in the course of Hospital's application to or participation in the Program, except as permitted by the other party or under compulsion of law. "Confidential Information" means any information that is not generally available to the public.

- Any notices or communications required for the license shall be in writing via electronic mail to the contact person(s) designated by IDSA and Hospital and shall become effective upon receipt unless the recipient responds otherwise.
- IDSA may terminate Hospital's participation in the Program for the Hospital's breach of 1) these Terms and Conditions; or 2) any other applicable requirements or obligations under the Program upon written notice and Hospital's failure to cure such breach within ten (10) days of the written notice.

Name of Hospital representative*
Title*