

**MARYLAND COMMISSION ON KIDNEY DISEASE**

4201 Patterson Avenue, Room 319  
Baltimore, MD 21215  
410-764-4799 \*Fax 410 358-3083

**FACILITY UPDATE INFORMATION**

Name of Facility: \_\_\_\_\_

Address of Facility: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Days and Hours of Operation: \_\_\_\_\_

Back up Hospital(s): \_\_\_\_\_

Transplant Affiliation(s): \_\_\_\_\_

Initial ESRD Certification Date: \_\_\_\_\_ Number of Stations: \_\_\_\_\_

Types of Dialysis Offered: \_\_\_\_\_

Total Number of Patients: \_\_\_\_\_ Number of Transplant Patients: \_\_\_\_\_

Hemo: \_\_\_\_\_ CAPD: \_\_\_\_\_ CCPD: \_\_\_\_\_ Home Dialysis: \_\_\_\_\_

Chief Executive Officer: \_\_\_\_\_ Phone: \_\_\_\_\_

Area Administrator: \_\_\_\_\_ Phone: \_\_\_\_\_

Administrator: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Director: \_\_\_\_\_ Phone: \_\_\_\_\_

Director of Nursing: \_\_\_\_\_ Phone: \_\_\_\_\_

Social Worker: \_\_\_\_\_ Phone: \_\_\_\_\_

Dietitian: \_\_\_\_\_ Phone: \_\_\_\_\_

Additional Information:

**COMMISSION USE ONLY**

CERTIFICATION NUMBER _____	CERTIFICATION STATUS: _____
LAST SURVEY DATE: _____	FEE PAID: _____
LICENSING SURVEY: _____	DATE AND INITIALS: _____