PUBLIC HEALTH ACCREDITATION BOARD

Statement of Intent
Instructions

All health departments planning to apply for accreditation must submit this Statement of Intent (SOI) after completion of the online orientation and prior to the submission of the application.

This document serves as the health department's SOI and states their intention to submit an application for accreditation in the future; however it does not commit the health department. Once received by PHAB, this SOI is valid for a period of up to 12 months.

With receipt of this SOI, PHAB will place your health department in the queue for training. PHAB will send the health department information and updates after the submission of this SOI. Updates will include notifications from PHAB of when you have been scheduled for training.

As your health department prepares for accreditation, PHAB encourages you to contact your membership organization for available technical assistance: Association of State & Territorial Health Officials (ASTHO) (www.astho.org), National Association of County & City Health Officials (NACCHO) (www. naccho.org), and National Indian Health Board (NIHB) (WWW.nihb.org).

SOI Instructions:

1. Complete the "Required Information" section on pages 2, 3, and 4
2. Sign & date by the Health Director or equivalent on page 4
3. Attach a one-page narrative describing the health department

STATEMENT OF INTENT

Date: _____

Name of Health Department:

Primary Office Address:

Name of Health Director:

Email address:

Telephone Number:

FAX Number:

Name of Appointing Authority (the group or person that hires the director of the Health Department): _____

Will this application include multiple jurisdictions? ☐ yes ☐ no

If yes, the health department listed on the Statement of Intent will serve as the lead health department for purposes of communication with PHAB. The designated Accreditation Coordinator will be the Coordinator for all jurisdictions.

If yes, please complete the one-page narrative and the required information with consolidated information for all departments who will partner for the application.

Name of Health Department:

Name of Accreditation Coordinator (AC) & Title:

E-Mail:

Phone:

Did the Accreditation Coordinator complete the online PHAB Orientation? ☐ yes ☐ no

Who else in your health department completed the online PHAB Orientation?

Name Title:

Name Title:

Name Title:

Name Title:

Name Title:

Organizational Structure*:

_____ Local Health Department
- ☐ City
- ☐ County
- ☐ District
- ☐ Regional
- ☐ City-County
- ☐ Multi –Jurisdictional (multi- county, district or region)
- ☐ Other _____

_____ State Health Department
- ☐ Centralized
- ☐ Decentralized
- ☐ Mixed/Hybrid

_____ Tribal
- ☐ Single Tribe
- ☐ Tribal Association/Consortium

_____ Territory

**See the PHAB Guide to Accreditation for an explanation of these designations.*

Name of Health Department:

Please complete the following:

A group of local health departments considering a multi-jurisdiction application should provide one answer representative of the combined jurisdictions.

A site includes any location where the health department has operations that it manages, including clinical, administrative, and environmental.

Health departments' current fiscal year budget _____

Number of population served by the health department(s) _____

Number of staff (FTE's) employed by the health department(s) _____

Number of separate sites operated by the health department(s)_____

I certify that the information contained in this Statement of Intent is accurate to the best of my ability. I understand the Statement of Intent is a document that shows our health department's plan to submit a future application to PHAB. I understand this statement does not commit our health department to submitting an application.

_____

Health Department Director Signature Date

If this is a multi-jurisdictional application, please include the signatures of all Health Department Directors:

_____

Health Department Director Signature Date

_____

Health Department Director Signature Date

_____

Health Department Director Signature Date