



## **East Texas Gulf Coast Regional Trauma Advisory Council**

### **ACKNOWLEDGEMENT**

Review the various System Plans below. These can be located on the RAC website at [https://irp.cdn-website.com/1f005d4d/files/uploaded/Regional\\_System\\_Plan\\_06\\_05\\_26.pdf](https://irp.cdn-website.com/1f005d4d/files/uploaded/Regional_System_Plan_06_05_26.pdf). This attestation may be completed by your Medical Director or the RAC Representative. Place your initial next to each plan. Once you have initialed all items, provide the name of your facility / service, your signature, title and date of completion. Return this document with your FY 27 Membership Packet no later than August 31, 2026.

\_\_\_\_\_ I have read and reviewed the East Texas Gulf Coast **Regional System Plan**. I understand this is a regional and overarching plan and may not reflect the practice of my institution.

\_\_\_\_\_ I have read and reviewed the East Texas Gulf Coast Regional **Trauma Plan** located on page 18 of the Regional System Plan. I understand this is a regional and overarching plan and may not reflect the practice of my institution.

\_\_\_\_\_ I have read and reviewed the East Texas Gulf Coast Regional **Acute Care Plan** located on page 24 of the Regional System Plan. I understand this is a regional and overarching plan and may not reflect the practice of my institution.

\_\_\_\_\_ I have read and reviewed the East Texas Gulf Coast Regional **Perinatal Plan** located on page 30 of the Regional System Plan. I understand this is a regional and overarching plan and may not reflect the practice of my institution.

\_\_\_\_\_ I have read and reviewed the East Texas Gulf Coast Regional **Performance Improvement Plan** located on page 32 of the Regional System Plan. I understand this is a regional and overarching plan and may not reflect the practice of my institution.

I have read and reviewed the plans as listed above. I understand these are regional and overarching plans and may not reflect the practice of my service or institution.

\_\_\_\_\_  
Name of Facility / Service

\_\_\_\_\_  
Name of Medical Director or RAC Representative.

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature of Medical Director or RAC Representative

\_\_\_\_\_  
Date