

PLANNING, DESIGN AND CONSTRUCTION

SPACE ALLOCATION/ALTERATION REQUEST/AUTHORIZATION FORM



UNIVERSITY OF EL PASO
MEDICAL CENTER
OF EL PASO

Use this form to request space changes (ie. change of existing space, new space, expansions, reductions and/or relocations). You may require a cost center for expenses. Please note that any request for new furniture can take 6-8 wks on average for delivery unless an alternative and/or temporary solution can be provided. Save and maintain a copy of the completed form for your records.

CONTACT INFORMATION

Requesting Department/Point of Contact:

Budget

First Name Jeannie

Department EPCH Operating Room

Last Name Shah *request #1*

Title/Position Associate Administrator

E-Mail Address jeannie.shah@elpasochildren

Cost Center 70660

SPACE REQUIREMENTS

What type of space are you requesting?

Administrative/Office ☐ Clinical/Service Instruction/Research ☐ Storage ☒ Other (Please specify below)

Alteration of current space needed? Yes ☒ No ☐ OR 4

Allocation of new space needed? Yes ☐ No ☒

Describe why new/additional space is needed. Attach supporting documents if appropriate.
Address the implications to your program/service if additional space is not approved.

Upgrade OR 4 so EPCH will have the ability to perform cardiac surgery. If the operating room is not upgraded, pediatric cardiac surgery cannot be performed. Currently, pediatric patients who need cardiac surgery have to leave El Paso. This is a service needed so patients can stay in El Paso.

Date space will be needed: As soon as possible

How many individuals will be assigned to this space. (Specify full-time or part time for each space requested.)

Full time for all Operating room staff, anesthesia and physicians

Do you have a space in mind? If so, why is this space adequate? Who and what is currently there?

OR 4. Largest operating room and can accommodate additional equipment

What attempts have been made to locate space within your current space allocation? Has under utilized space been assessed to solve this need? Have shared space possibilities been explored?

SPACE REQUIREMENTS CONTINUED

If space will be vacated by approval of this request, please indicated if current space will be released or describe the space backfill proposal.

Not applicable

Facility needs (Please indicate any electrical, HVAC, storage, plumbing, etc.). IT needs: be specific (how many outlet/data ports in each room needed.)

HVAC, electrical, medical gases, WAGD, vacuum

Furniture needs: Does any new furniture need to be purchased? if relocating, what furniture will be transferred to new space?

Not applicable

Provide information on any time constraints that may affect the timing of allocation of the space.

REQUEST TO CHANGE FUNCTION OF SPACE (IF APPLICABLE)

Building & Room Number: EPCH OR 4

Current Room Type: Operating Room

Requested Room Type Change: No changes

Justification for Change: Adding cardiac surgical services

Will this require a State Application? (see below)

An application is required for construction, erection, repair, remodeling, renovations, modifications, additions, alterations, removal, conversion, change of service(s), change of function, change of licensed beds or ESRD stations, change of licensed facility type, large/stationary equipment replacement, building system equipment upgrade, demolition, initial facility license or re-opening a closed General or Special Hospital, Private Psychiatric Hospital or Crisis Stabilization Unit, Ambulatory Surgical Center, End Stage Renal Disease Facility, Freestanding Emergency Medical Care Facility, or Special Care Facility.

AUTHORIZATION SIGNATURES

Chief Operating Officer:

Comments:

Assistant Administrator of Planning, Design & Construction:

Comments:

Assistant Administrator of Facilities:

Comments:

Approving Supervisor of Applicant's Department: