Lung Transplant Program

PART 3A: Personnel – Transplant Program Director(s)

1. Identify the Transplant Program Surgical and/or Medical Director(s) of the lung transplant program (include C.V.). Briefly describe the leadership responsibilities for each.

Check list	Question Reference	Required Supporting Documents
	3A 1	Current C.V.

Name	Date of Appointment	Primary areas of responsibility

PART 3B, Section 1: Personnel – Surgical – Primary Surgeon

1. Primary Lung Transplant Surgeon. Refer to the Bylaws for the necessary qualifications and more specific descriptions of the required supporting documents listed below.

Check list	Question Reference	Required Supporting Documents
	3B 1a	Current C.V.
	3B 1b	Letter from the Credentialing Committee of the applicant hospital stating that the surgeon meets all requirements to be in good standing. Please provide an explanation of any status other than active/full
	3B 1c,g,h	Letter from the Surgeon detailing his/her commitment to the program and describing their transplant experience/training.
	3B 1f	Formal Training: A letter from training director verifying that the fellow has met the requirements
	3B 1f	Formal Training: A log (organized by date) of the transplant and procurement procedures.
	3B 1g	Transplant Experience: A letter from program director verifying that the fellow has met the requirements
	3B 1g	Transplant Experience: A log (organized by date) of the transplant and procurement procedures. (See Tables ! and 2.
		Other Letters of Recommendation (Reference)
	4a	Letter of recommendation attesting to the individual's overall qualifications to act as primary surgeon and addressing the individual's personal integrity, honesty, familiarity with and experience in adhering to OPTN requirements and compliance protocols, and other matters as deemed appropriate.

a) Name: _____

b) Date of Appointment (MM/DD/YY): Facility: _____ To this position: _____

Does individual have FULL Privileges at this hospital?

_____ Yes Provide copy of hospital credentialing letter.

_____ No If the individual does **not** have full privileges, explain why and provide the date the individual will be considered for full privileges. Include an explanation that describes the scope of privileges.

c) Percentage of professional time spent at this facility: _____% = _____ hrs/week

d) List below the hospitals, health care facilities, and medical group practices and percentage of professional time this individual is on site at each:

Facility	Type	Location (city, state)	% Professional time Spent on site

e) Board certification type (s) or equivalent. If board certification is pending, indicate the date the exam has been scheduled. If individual has been recertified, **please use that date**.

Certification Type	Effective Date (MM/DD/YY)	Certification Number

f) Formal Training: List the name of the institution(s) in which lung and/or heart/lung transplant training (residency/fellowship) was received including Program Director(s) names, applicable dates, and the number of transplant procedures performed. Refer to the Bylaws for the necessary qualifications and descriptions of the required supporting documents listed below unless the individual meets the pathway for post fellowship experience as described in the requirements:

- A letter from program director verifying that the fellow has met the requirements.
- A log (See Tables 1 and 2) of the transplant and procurement procedures. The log should include a patient identifier/OPTN ID Number, transplant/procurement date and the surgeon's role in the procedure (i.e., primary or 1st assistant). These logs must be signed by the director of the training program.

Date From – To MM/DD/YY	**Institution**	**Program Director**	**# LU Transplants as Primary**	**# HL Transplants as Primary**	**# LU Transplants First Assisted**	**# HL Transplants First Assisted**	**# of LU Procurements**	**# HL Procurements**
Residency: _____ to _____								
Fellowship _____ to _____								

g) Transplant Experience (Post fellowship):
List the name of the institution(s), applicable dates, and number of lung and/or heart/lung transplants performed by the individual at each institution. Refer to the Bylaws for the necessary qualifications and descriptions of the required supporting documents listed below.

- Letter(s) of reference from the program director(s) listed below.
- A log (See Tables 1 and 2) of the transplant and procurements procedures. The log should include a patient identifier/OPTN ID Number, transplant/procurement date and the surgeon's role in the procedure (i.e., primary or 1st assistant).
  The transplant log(s) should be signed by the program director, division chief, or department chair from the program where the experience was gained.

Date From – To MM/DD/YY	**Institution**	**Program Director**	**# LU Transplants as Primary**	**# HL Transplants as Primary**	**# LU Transplants First Assisted**	**# HL Transplants First Assisted**	**# of LU Procurements**	**# HL Procurements**

h) Summarize how the surgeon's experience fulfills the membership criteria.
(Check all that apply)

Membership Criteria	Yes
1. On site	
2. Certified by the American Board of Thoracic Surgery or the equivalent	
3. Thoracic Surgery Boards pending	
4. Cardiothoracic Surgery Residency	
a. Primary surgeon or first assist on 15 or more lung and/or heart/lung transplant procedures	
b. Involved in all levels of pre-, peri-, and post-operative patient care years within the last 2 years	
c. Training program approved by American Board of Thoracic Surgery	
d. Primary surgeon or first assist on 10 or more lung procurement procedures	
5. 12-Month Transplant Fellowship	
a. Primary surgeon or first assist on 15 or more lung and/or heart/lung transplant procedures	
b. Involved in all levels of pre-, peri-, and post-operative patient care within the last 2 years	
c. Training program approved by American Board of Thoracic Surgery	
d. Primary surgeon or first assist on 10 or more lung procurement procedures	
6. Two to five years of experience (Post fellowship)	
a. Primary surgeon or first assist on 15 or more lung transplant procedures over a minimum of 2 years and a maximum of 5 years. Of these 15, at least 10 were performed as primary surgeon	
b. Involved in all levels of pre, peri, and post-operative patient care within the last 2 years	
c. Performed 10 or more lung procurement procedures	
7. Pediatric Pathway	
a. Program serves predominantly Pediatric Patients	
b. Demonstrate that the individual has maintained current working knowledge in all aspects of lung transplantation and patient care within the last 2 years.	
c. Petition the MPSC for approval	
d. A preliminary interview before the Committee shall be required	

i) Describe in detail the proposed primary surgeon's level of involvement in this transplant program, and if applicable, describe the surgeon's plan for coverage of transplant programs located in multiple transplant centers. (Expand rows below as necessary).

	Describe Level of Involvement
Care of Acute and Chronic Lung Failure	
Cardiopulmonary Bypass	
Donor Selection	
Recipient Selection	
Pre- and Postoperative Ventilator Care	
Transplant Surgery	
Postoperative Immunosuppressive Therapy	
Histologic Interpretation and Grading of Lung Biopsies for Rejection	
Long-term Outpatient follow-up	
Coverage of Multiple Transplant Centers (if applicable)	
Additional Information:	

j) Describe the proposed primary surgeon's transplant training and experience in the areas listed below. (Expand rows below as necessary).

	Describe Experience /Training
Care of Acute and Chronic Lung Failure	
Cardiopulmonary Bypass	
Donor Selection	
Recipient Selection	
Pre- and Postoperative Ventilator Care	
Transplant Surgery	
Postoperative Immunosuppressive Therapy	
Histologic Interpretation and Grading of Lung Biopsies for Rejection	
Long-term Outpatient follow-up	
Additional Information:	

Additional Instructions for PART 3B, Section 2: Personnel – Surgical

Complete this section of the application to describe the involvement, training, and experience of any other surgeons participating in the program. **Surgeons must be designated as Additional or Other as described below**.

The Bylaws provide the following definition of Additional Transplant Surgeon:

> *Additional Transplant Surgeons must be credentialed by the institution to provide transplant services and be able to independently manage the care of transplant patients including performing the transplant operation and procurement procedures.*

Surgeons that also support this program but who do not meet the definition of "primary" or additional," should complete this section as well. The type should be indicated as "other."

Duplicate pages as needed.

PART 3B, Section 2: Personnel – Surgical

2. List Additional/Other Surgeons (Duplicate this section as needed). Provide the following attachments:

Check list	Question Reference	Required Supporting Documents
	3B 2a	Current C.V.
	3B 2b	A letter from the Credentialing Committee of the applicant hospital stating that the surgeon meets all requirements to be in good standing. Please provide an explanation of any status other than active/full.
	3B 2c,e,f	A letter from the Surgeon detailing his/her commitment to the program and level of involvement in substantive patient care.

a) Name: _____

For lung transplantation this individual is classified as ____ Additional Surgeon ___ other Surgeon
(Check only one)

b) Date of appointment (MM/DD/YY) at this Facility: _____ To this position: _____

Does individual have FULL Privileges at this hospital?

_____ Yes Provide copy of hospital credentialing letter.

_____ No If the individual does **not** have full privileges, explain why and provide the date the individual will be considered for full privileges. Include an explanation that describes the scope of privileges.

c) Percentage of professional time spent on site: _____% = _____ hrs/week

d) Board certification type (s) or equivalent. If board certification is pending, indicate the date the exam has been scheduled. If individual has been recertified, **please use that date.**

Certification Type	Effective Date (MM/DD/YY)	Certification Number

e) Training (Residency/Fellowship): List the name of the institution(s) in which lung and/or heart/lung transplant training (fellowship) was received including Program Director(s) names, applicable dates, and the number of transplants the individual performed.

Date From – To MM/DD/YY	**Institution**	**Program Director**	**# LU Transplants as Primary**	**# HL Transplants as Primary**	**# LU Transplants First Assisted**	**# HL Transplants First Assisted**	**# of LU Procurements**	**# HL Procurements**
Residency: _____ to _____								
Fellowship _____ to _____								

f) Transplant Experience (Post fellowship): List the name of the institution(s), applicable dates, and number of lung and/or heart/lung transplants performed by the individual at each institution.

Date From – To MM/DD/YY	**Institution**	**Program Director**	**# LU Transplants as Primary**	**# HL Transplants as Primary**	**# LU Transplants First Assisted**	**# HL Transplants First Assisted**	**# of LU Procurements**	**# HL Procurements**

g) Describe the surgeon's level of involvement in this lung transplant program in the areas listed below. (Expand rows as necessary)

	Describe Level of Involvement
Care of Acute and Chronic Lung Failure	
Cardiopulmonary Bypass	
Donor Selection	
Recipient Selection	
Pre- and Postoperative Ventilator Care	
Transplant Surgery	
Postoperative Immunosuppressive Therapy	
Histologic Interpretation and Grading of Lung Biopsies for Rejection	
Long-term Outpatient follow-up	
Additional Information:	

h) Describe the surgeon's lung transplant training and experience in the areas listed below. (Expand rows as necessary)

	Describe Experience /Training
Care of Acute and Chronic Lung Failure	
Cardiopulmonary Bypass	
Donor Selection	
Recipient Selection	
Pre- and Postoperative Ventilator Care	
Transplant Surgery	
Postoperative Immunosuppressive Therapy	
Histologic Interpretation and Grading of Lung Biopsies for Rejection	
Long-term Outpatient follow-up	
Additional Information:	

PART 3C, Section 1: Personnel – Medical – Primary Physician

1. Primary Lung Transplant Physician. Refer to the Bylaws for necessary qualifications. Provide the attachments listed below.

Check list	Question Reference	Required Supporting Documents
	3C 1a	Current C.V.
	3C 1b	Letter from the Credentialing Committee of the applicant hospital stating that the physician meets all requirements to be in good standing. Please provide an explanation of any status other than active/full.
	3C 1c,f,g	Letter from the Physician detailing his/her commitment to the program; level of involvement with substantive patient care; and summarizing their previous transplant experience.
	3C 1f	Formal Training: A letter from training director verifying that the fellow has met the requirements
	3C 1f	Formal Training: A log (organized by date) of the transplant patients followed. (See Table 3)
	3C 1g	Transplant Experience: A letter from program director verifying that the fellow has met the requirements
	3C 1g	Transplant Experience: A log (organized by date) of the transplant patients followed. (See Table 3)
	3C	Other Letters of Recommendation (Reference)
	4a	Letter of recommendation attesting to the individual's overall qualifications to act as primary physician and addressing the individual's personal integrity, honesty, familiarity with and experience in adhering to OPTN requirements and compliance protocols, and other matters as deemed appropriate

a) Name:_____

b) Date of Appointment (MM/DD/YY): Facility: _____ To this position: _____

Does individual have FULL Privileges at this hospital?

_____ Yes Provide copy of hospital credentialing letter.

_____ No If the individual does **not** have full privileges, explain why and provide the date the individual will be considered for full privileges. Include an explanation that describes the scope of privileges.

c) Percentage of professional time on site: _____% = _____ hrs/week

d) List other hospitals, health care facilities, and medical group practices and percentage of professional time on site at each:

Facility	Type	Location (city, state)	% Professional time Spent on site

e) Board certification type (s) or equivalent. If board certification is pending, indicate the date the exam has been scheduled. If individual has been recertified, **please use that date.**

Certification Type	Effective Date (MM/DD/YY)	Certification Number

f) Training (Fellowship): List the program(s) in which lung and/or heart/lung transplant training was received including name of institution(s), Program Director(s) names, applicable dates, and the number of transplant patients for which the physician provided substantive patient care (pre-, peri- and post-operatively from the time of transplant). Refer to the Bylaws for the necessary qualifications and descriptions of the required supporting documents listed below unless the individual meets the pathway for post fellowship experience as described in the requirements.

- Letters from the Director of fellowship training program and the supervising physician verifying that the fellow has met the requirements.
- A recipient log (See Table 3) that includes the date of transplant, the patient's medical record and/or OPTN ID number. This log must be signed by the director of the training program and/or primary transplant physician at that transplant program.
-

Date From To mm/dd/yy	Institution	Program Director	# LUNG Patients Followed:			# HEART/LUNG Patients Followed:		
			Pre	Peri	Post	Pre	Peri	Post

g) Experience (Post fellowship only): List the name of the institution(s) and applicable dates, number of lung and/or heart/lung transplants performed at the institution for whom the Transplant Physician accepted primary responsibility for substantive patient care (pre-, peri-, and post-operatively from the time of transplant). Refer to the Bylaws for the necessary qualifications and descriptions of the required supporting documents listed below.

- Two supporting letters - at least one must be from the lung transplant surgeon with whom the pulmonologist has previously worked.
- A recipient log (See Table 3) that includes the date of transplant, the patient's name and/or OPTN ID number. This log should be signed by the program director, division chief, or department chair from the program where the experience was gained.

Date From To mm/dd/yy	Institution	Program Director	# LUNG Patients Followed:			# HEART/LUNG Patients Followed:		
			Pre	Peri	Post	Pre	Peri	Post

h) Training/Experience. Describe how the physician fulfills the requirements for participation as an observer in three multiple organ procurements and three transplants that include the lung, as well as observing the evaluation of the donor and donor process, and management of at least 3 multiple organ donors which include the lung and/or heart/lung.

- Provide a log (See Table 4) of these cases that includes the date of procurement, medical record ID number and/or OPTN ID number, and the location of the donor.
- If these requirements have not been met, submit a plan explaining how the individual will fulfill them.

Date From To mm/dd/yy	**Institution**	**# of LU Procurements Observed**	**# of LU Transplants Observed**	**# of LU Donors Donor Process**	**# of Multi-Organ Donors Observed Mgmt.**

i) Summarize how the Transplant Physician's experience fulfills the membership criteria for membership. (Check all that apply)

Membership Criteria	**Yes**
1. On site	
2. M.D., D.O. or equivalent degree	
3. Certified in pulmonary medicine by the American Board of Internal Medicine, Pediatrics or the foreign equivalent	
4. Board certified in Pulmonary Medicine	
5. Achieved eligibility in Pulmonary Medicine	
6. Direct involvement in lung transplant patient care within the last 2 years	
7. Pulmonary Medicine fellowship	
a. Participated in the care of 15 or more lung and/or heart/lung transplant patients for a minimum of 3 months from the time of their transplant	
b. Observed 3 or more lung procurement procedures and transplants	
c. Involved with all aspects of lung transplant patient care	
d. Observe the evaluation of the donor and donor process, and management of at least 3 multiple organ donors which include the lung and/or heart/lung	
8. 12-Month Transplant Pulmonology Fellowship	
a. Participated in the care of 15 or more lung and/or heart/lung transplant patients for a minimum of 3 months from the time of their transplant	
b. Observed 3 or more lung procurement procedures and transplants	
c. Involved with all aspects of lung transplant patient care	
d. Observe the evaluation of the donor and donor process and management of at least 3 multiple organ donors that include the lung or heart/lung	
9. Experience in lung transplantation	
a. 2-5 years experience on an active lung transplant service	
b. Involved with the care of 15 or more lung and/or heart/lung transplant patients for a minimum of 3 months from the time of their transplant	
c. Observed 3 or more lung procurement procedures and 3 transplants	
d. Observed the evaluation of the donor and donor process and management of at least 3 multiple organ donors that include the lung or heart/lung	
10. Pediatric Pathway	
a. Program serves predominantly Pediatric Patients	
b. Demonstrate that the individual has maintained current working knowledge in all aspects of lung transplantation and patient care within the last 2 years.	
c. Petition the MPSC for approval	
d. A preliminary interview before the Committee shall be required	

Membership Criteria	Yes
11. 12-Month Conditional Pathway - *Only available to Existing Programs*	
a. Certified Pulmonologist	
b. Participated in the primary care of 8 or more lung and/or heart/lung transplant recipients and has followed these patients for a minimum of 3 months from the time of their transplant. At least one-half of these patients must be single and/or double lung transplant recipients	
c. If Qualifying by virtue of acquired clinical experience, this experience must be equal to 12 months on an active lung transplant service acquired over a maximum of 2 years.	
d. A consulting relationship with counterparts at another UNOS member transplant center (include letter of support)	

j) Describe in detail the proposed primary transplant physician's involvement in the management of patients in this program and, if applicable, their plan for coverage of multiple transplant centers. (Expand rows as necessary).

Areas of Involvement in this program	Description
Candidate Evaluation Process	
Care of Acute and Chronic Lung Failure	
Cardiopulmonary Bypass	
Donor Selection	
Recipient Selection	
Pre- and Postoperative Ventilator Care	
Postoperative Immunosuppressive Therapy	
Histologic Interpretation and Grading of Lung Biopsies for Rejection	
Long-term Outpatient Follow-up	
Coverage of Multiple Transplant Centers (if applicable)	
Additional Information	

k) Describe the proposed primary physician's transplant training and experience in the areas listed below. (Expand rows as necessary)

Experience and Training	**Description of Individual's current working knowledge in the these areas**
Candidate Evaluation Process	
Care of Acute and Chronic Lung Failure	
Cardiopulmonary Bypass	
Donor Selection	
Recipient Selection	
Pre- and Postoperative Ventilator Care	
Postoperative Immunosuppressive Therapy	
Histologic Interpretation and Grading of Lung Biopsies for Rejection	
Long-term Outpatient Follow-up	
Additional Information	

Additional Instructions for PART 3C, Section 2: Personnel – Physicians

Complete this section of the application to describe the involvement, training, and experience of other physicians associated with the program. **Physicians must be designated as Additional or Other as described below**.

The Bylaws provide the following definition of Additional Transplant Physician:

> *Additional Transplant Physicians must be credentialed by the institution to provide transplant services and be able to independently manage the care of transplant patients.*

Physicians that also support this program but who do not meet the definition of "primary" or "additional," should complete this section of the application. The type should be indicated as "other."

Duplicate pages as needed

PART 3C, Section 2: Personnel – Physicians

2. **Additional Physicians (Duplicate this section as needed).** Refer to the Bylaws for the necessary qualifications and descriptions of the required supporting documents listed below.

Check list	Question Reference	Required Supporting Documents
	3C 2a	Current C.V.
	3C 2b	A letter from the Credentialing Committee of the applicant hospital stating that the physician meets all requirements to be in good standing. Please provide an explanation of any status other than active/full.
	3C 2c,e,f	A letter from the Physician detailing his/her commitment to the program and level of involvement in substantive patient care.

a) Name: _____

For lung transplantation this individual is classified as ____ Additional Physician ___ other Physician
(Check only one)

b) Date of Appointment (MM/DD/YY): Facility: _____ To this position: _____

Does individual have FULL Privileges at this hospital?
_____ Yes Provide copy of hospital credentialing letter.
_____ No If the individual does **not** have full privileges, explain why and provide the date the individual will be considered for full privileges. Include an explanation that describes the scope of privileges.

c) Percentage of professional time spent on site: _____% = _____ hrs/week

d) Board certification type (s) or equivalent. If board certification is pending, indicate the date the exam has been scheduled. If individual has been recertified, please use that date.

Certification Type	Effective Date (MM/DD/YY)	Certification Number

e) Training (Fellowship): List the program(s) in which lung and/or heart/lung transplant training was received including name of institution(s), Program Director(s) names, applicable dates, and the number of transplant patients followed for which the physician provided substantive care (pre-, peri- and post-operatively from the time of transplant).

Date From To mm/dd/yy	Institution	Program Director	# LUNG Pts. Followed:			# HEART/LUNG Pts. Followed:		
			Pre	Peri	Post	Pre	Peri	Post

f) Transplant Experience (Post fellowship only): List the name of institution(s), applicable dates, and the number of lung and/or heart-lung transplants performed at the institution for whom the Transplant Physician accepted primary responsibility for substantive patient care (pre-, peri- and post-operatively from the time of transplant).

Date From To mm/dd/yy	Institution	Program Director	# LUNG Pts. Followed:			# HEART/LUNG Pts. Followed:		
			Pre	Peri	Post	Pre	Peri	Post

g) Describe in detail the transplant physician's involvement in this lung transplant program. (Expand rows as necessary)

Areas of Involvement in this program	**Description**
Candidate Evaluation Process	
Care of Acute and Chronic Lung Failure	
Cardiopulmonary Bypass	
Donor Selection	
Recipient Selection	
Pre- and Postoperative Ventilator Care	
Postoperative Immunosuppressive Therapy	
Histologic Interpretation and Grading of Lung Biopsies for Rejection	
Long-term Outpatient Follow-up	
Additional Information	

h) Describe the physician's transplant training and experience in the role of transplant patient management in the areas listed below. (Expand rows as necessary).

Areas of Involvement in this program	**Description**
Candidate Evaluation Process	
Care of Acute and Chronic Lung Failure	
Cardiopulmonary Bypass	
Donor Selection	
Recipient Selection	
Pre- and Postoperative Ventilator Care	
Postoperative Immunosuppressive Therapy	
Histologic Interpretation and Grading of Lung Biopsies for Rejection	
Long-term Outpatient Follow-up	
Additional Information	

PART 4: Certification of Investigation

The Bylaws state that "***Each primary surgeon or primary physician****, listed on the application as a part of the plan for who shares coverage responsibility, shall submit an assessment, subject to medical peer review confidentiality requirements and which follows guidelines provided in the application and is satisfactory to the MPSC, of* ***all physicians and surgeons*** *participating in the program regarding their involvement in prior transgressions of UNOS requirements and plans to ensure that the improper conduct is not continued." (Emphasis Added)*

a) This hospital has conducted its own peer review of all surgeons and physicians listed below to ensure compliance with applicable OPTN/UNOS Bylaws.

Names of Surgeons*

Names of Physicians*

b) If prior transgressions were identified has the hospital developed a plan to ensure that the improper conduct is not continued? ____ Yes ___ No ___ Not Applicable

c) What steps will be/were taken to correct the prior improper conduct or to ensure the improper conduct is not repeated in this program? Provide a copy of the plan.

I certify that this review was performed for each named surgeon and physician according to the hospital's peer review procedures.

Signature of Primary Surgeon: Date:

Print name:

Signature of Primary Physician: Date:

Print name:

* Expand rows as needed

Part 5 - OPTN Staffing Report

LUNG TRANSPLANT PROGRAM

Member Code:	Name of Hospital:	
Main Program Phone Number	Main Program Fax Number:	Hospital URL: http://www
Toll Free Phone numbers for Patients: Hospital #:	Program #:	

Answer the questions below for this transplant program. Since this information will be used to update UNET[sm] and the Membership Directory, make sure to include the best (most accurate) telephone number and address for each person. Use additional pages as necessary.

Identify the **Transplant Program Medical and/or Surgical Director(s)**:

Name	Address	Phone	Fax	Email

The **surgeons** who participate in this transplant program are:

Name	Address	Phone	Fax	Email

The **physicians** (internists) who participate in this transplant program are:

Name	Address	Phone	Fax	Email

Identify the **Hospital Administrative Director/Manager** who will be involved with this program: **Use an * to indicate** which individual will serve as the primary Transplant Administrator if more than one.

Name	Address	Phone	Fax	Email

Identify the **Financial Counselor(s)** who will be prominently involved with this program:

Name	Address	Phone	Fax	Email

The **clinical transplant coordinators** who participate in this transplant program are:

Name	Address	Phone	Fax	Email

List the **data coordinators** for this transplant program below. **Use an * to indicate** which individual will serve as the primary data coordinator.

Name	Address	Phone	Fax	Email

Identify the **Social Worker(s)** who will be prominently involved with this program:

Name	Address	Phone	Fax	Email

Identify the **Pharmacist (s)** who will be prominently involved with this program:

Name	Address	Phone	Fax	Email

Identify the **Director of Anesthesiology** who will be prominently involved with this program:

Name	Address	Phone	Fax	Email

TABLE 1 – Primary Surgeon - Transplant Log (Sample)

Organ	
Name of Proposed Primary Surgeon:	
Name of hospital where transplants were performed:	
Date range of surgeon's appointment/training: MM/DD/YY TO MM/DD/YY	

List cases listed in date order

#	Date of Transplant	PT ID	Primary Surgeon	1st Assistant
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				

Director's Signature: _____ Date: _____

Extend lines on log as needed

TABLE 2 **Primary Surgeon - Procurement Log** (Sample)

Organ	
Name of Proposed Primary Surgeon:	
Name of hospital where surgeons was employed when procurements were performed:	
Date range of surgeon's appointment/training: MM/DD/YY TO MM/DD/YY	

List cases listed in date order

#	Date of Procurement	Donor ID Number	Location of Donor (hospital)	Comments (LRD/CAD/Multi-organ)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
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27				
28				
29				
30				
31				
32				
33				
34				
35				

*extend lines on log as needed

Director's Signature: _____ Date: _____

TABLE 3 – Primary Physician Log (1) (Sample)

List only those patients followed for 3 months from the time of transplant (including pre-, peri-, and post-operative management)

Organ	
Name of Proposed Primary Physician:	
Name of hospital where transplants were performed:	
Date range of surgeon's appointment/training: MM/DD/YY TO MM/DD/YY	

List cases listed in date order

#	Date of Transplant	PT ID	Comments
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
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31			
32			
33			
34			
35			

Director's Signature: _____ **Date:** _____

Extend *lines on log as needed*

TABLE 4 Primary Physician Log (2) (Sample)

(Cases should be listed in date order)

Organ	
Name of Proposed Primary Physician:	
Name of hospital where transplants were performed:	
Date range of surgeon's appointment/training: MM/DD/YY TO MM/DD/YY	

In the tables below document how the physician fulfills the requirements for participation as an observer in organ procurements and transplants, as well as observing the selection and management of at least 3 multiple organ donors that include the organ for which application is being submitted. List cases in date order.

Procurements Observed

#	Date of Procurement	Medical Record/ OPTN ID #	Location of Donor (Hospital)
1			
2			
3			
4			
5			

Transplants Observed

#	Date of Transplant	Medical Record/ OPTN ID #	Location (Hospital)
1			
2			
3			
4			
5			

Donor Selection and Management

#	Date of Procurement	Medical Record/ OPTN ID #	Location of Donor (Hospital)	Specify Organ specific or Multi-organ?
1				
2				
3				
4				
5				