

Kidney Transplant Program Including Programs Performing Living Donor Kidney Transplantation

This application is for (check all that apply):

	Kidney Transplantation	Living Donor Kidney Transplantation	
		Open Nephrectomy	Laparoscopic Nephrectomy
New Program/ Initial Application			
Key Personnel Change			

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

1. Identify the Transplant Program Surgical and/or Medical Director(s) of the kidney transplant program (include C.V.). Briefly describe the leadership responsibilities for each individual, including their role in living donor kidney transplantation if applicable.

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 Kidney 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
	3,B,1a	Current C.V.
	3,B,1,c	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
	3,B,1,d,g,&h	Letter from the Surgeon detailing his/her commitment to the program and describing their transplant experience/training
	3,B,1,g	Formal Training: A letter from the training director verifying that the fellow has met the requirements
	3,B,1,g	Formal Training: A log (organized by date) of the transplant and procurement procedures (Tables 1 & 2)
	3,B,1,h	Transplant Experience: A letter from the program director verifying that the individual has met the primary surgeon requirements and is qualified to direct a kidney transplant program.
	3,B,1,h	Transplant Experience: A log (organized by date) of the transplant and procurement procedures
	3B	Other Letters of Recommendation (Reference)
	5a	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) This surgeon participates in (check all that apply):

<input type="checkbox"/>	Kidney Transplantation
<input type="checkbox"/>	Living Donor Kidney Transplantation

c) 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. Also include an explanation that describes the scope of privileges.

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

e) List other 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

f) 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

- g) **Formal Training:** List the name of the institution(s) in which kidney transplant training (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.
 - Logs (Tables 1 and 2) of the transplant and procurement procedures. The logs 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	# KI Transplants as Primary	# KI Transplants First Assisted	# of KI Procurements

- h) **Transplant Experience (Post fellowship):** List the name of the institution(s), applicable dates, program director's names, and number of kidney 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.
 - Logs (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).

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

- i) 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 Surgery, Urology, Osteopathic or the foreign equivalent	
3. 2 year Kidney Transplant Fellowship	
a. Primary surgeon or 1 st assistant on at least 30 kidney transplants	
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 Surgery	
d. Primary Surgeon or 1 st assistant on at least 15 or more kidney procurement procedures. At least 3 of these donors must be multiple organ and at least 10 must be deceased.	
e. Demonstrate that the individual has maintained current working knowledge in all aspects kidney transplantation and patient care within the last 2 years	
4. Experience (Post Fellowship)	
a. Primary surgeon or first assist on 45 kidney transplants over a minimum of 2 years and a maximum of 5 years	
b. Involved in all levels of pre-, peri-, and post-operative patient care within the last 2 years	
c. Primary surgeon or 1 st assistant on at least 15 kidney procurement procedures	
5. Pediatric Pathway	
a. Program serves predominantly Pediatric Patients	
b. Demonstrate that the individual has maintained current working knowledge in all aspects kidney 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	

- j) 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
Pre-Operative Patient Management	
Recipient Selection	
Donor Selection	
Transplant Surgery	
Post-Operative Care	
Histocompatibility and Tissue Typing	
Post-Operative Immunosuppressive Therapy	
Outpatient Follow-up	
Coverage of Multiple Transplant Centers (if applicable)	
Living Donor Transplantation (If applicable)	
Additional Information:	

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

	Describe Experience /Training
Pre-Operative Patient Management	
Recipient Selection	
Donor Selection	
Transplant Surgery	
Post-Operative Care	
Post-Operative Immunosuppressive Therapy	
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. Additional and Other Surgeons (Duplicate this section as needed). Provide the requested attachments.

Check list	Question Reference	Required Supporting Documents
	3,B,2,a	Current C.V.
	3,B,2,c	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.
	3,B,2,d,f, & g	A letter from the Surgeon detailing his/her commitment to the program and level of involvement in substantive patient care.

a) Name: _____

b) This surgeon participates in (check all that apply):

Active Yes/No		Type	
		Additional	Other
	Kidney Transplantation		
	Living Donor Kidney Transplantation		

c) 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.

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

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 name of the institution(s) in which kidney 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	# KI Transplants as Primary	# KI Transplants First Assisted	# of KI Procurements

- g) Transplant Experience (Post fellowship): List the name of the institution(s), program director name(s), applicable dates, and number of kidney transplants performed by the individual at each institution.

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

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

	Describe Level of Involvement
Pre-Operative Patient Management	
Recipient Selection	
Donor Selection	
Transplant Surgery	
Post-Operative Care	
Post-Operative Immunosuppressive Therapy	
Outpatient follow-up	
Living Donor Transplantation (if applicable)	
Coverage of Multiple Transplant Centers (if applicable)	
Additional Information	

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

	Describe Experience /Training
Pre-Operative Patient Management	
Recipient Selection	
Donor Selection	
Transplant Surgery	
Post-Operative Care	
Post-Operative Immunosuppressive Therapy	
Additional Information	

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

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

Check list	Question Reference	Required Supporting Documents
	3,C,1,a	Current C.V.
	3,C,1,c	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.
	3,C,1,d,g & h	Letter from the Physician detailing his/her commitment to the program; level of involvement with substantive patient care; and summarizing their previous transplant experience.
	3,C,1,g	Formal Training: A letter from the training director verifying that the fellow has met the requirements
	3,C,1,g	Formal Training: A log (organized by date) of the transplant patients followed. Complete Table 3.
	3,C,1,h	Transplant Experience: A letter from the program director verifying that the individual has met the primary physician requirements and is qualified to direct a liver transplant program.
	3,C,1,h	Transplant Experience: A log (organized by date) of the transplant patients followed. Complete Table 3
	3,C,1,i	Training/Experience – participation as observer in procurements, transplant procedures, etc. (Complete Table 4)
	3C	Other Letters of Recommendation (Reference).
	5	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) This physician participates in (check all that apply):

<input type="checkbox"/>	Kidney Transplantation
<input type="checkbox"/>	Care of Living Kidney Donors

c) 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. Also, include an explanation that describes the scope of privileges.

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

e) 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

- f) 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

g) Training (Fellowship): List the program(s) in which kidney 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 the fellowship training program and the supervising physician verifying that the fellow has met the requirements.
- Recipient log(s) (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	# KI Patients Followed:		
			Pre	Peri	Post

h) Experience (Post fellowship only): List the name of the institution(s), program director name(s), applicable dates, and the number of kidney 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 kidney transplant surgeon with whom the nephrologist has previously worked.
- Recipient log(s) (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	# KI Patients Followed:		
			Pre	Peri	Post

- i) 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 kidney, as well as observing the evaluation of the donor and donor process, and management of at least 3 multiple organ donors
- Provide a log of these cases that includes the date of procurement, medical record ID number and/or OPTN ID number, and the location of the donor. Complete Table 4.
 - 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 KI Procurements Observed	# of KI Transplants Observed	# of KI Donors/ Donor Process	# of Multi-Organ Donors Observed Mgmt

- j) 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 by the American Board of Internal Medicine, Pediatrics or the foreign equivalent	
4. Board certified in Nephrology	
5. Nephrology Fellowship	
a. Participated in 12 month Nephrology fellowship	
b. Minimum of 30 kidney patients followed for a minimum of three months from the time of their transplant	
c. Experience with pre-, peri-, and post-operative patient care within the last 2 years	
d. Observed 3 procurement procedures and 3 kidney transplants	
e. Observe the evaluation of the donor and donor process, and management of at least 3 multiple organ donors which include the kidney	
7. Transplant Nephrology Fellowship	
a. Participated in 12 month specialized training, which consist of clinical transplant service, tissue typing laboratory, and solid organ transplant service.	
b. Minimum of 30 kidney patients followed for a minimum of three months from the time of transplant	
c. Experience with pre-, peri-, and post-operative care within the last 2 years	
d. Observed 3 procurement procedures and 3 kidney transplants	
e. Observe the evaluation of the donor and donor process, and management of at least 3 multiple organ donors which include the kidney	
8. Experience in kidney transplantation (Post Fellowship) involving:	
a. 2-5 years experience on an active kidney transplant service	
b. Minimum of 45 or more kidney patients followed from the time of their transplant for a minimum of 3 months	
c. Experience with pre-, peri-, and post-operative care within the last 2 years	
d. Observed 3 procurement procedures and 3 kidney transplants	
e. Observe the evaluation of the donor and donor process, and management of at least 3 multiple organ donors which include the kidney and/or kidney/pancreas	
9. Pediatric Pathway	
a. Program serves predominantly Pediatric Patients	
b. Demonstrate that the individual has maintained current working knowledge in all aspects of pancreas transplantation and patient care within the last 2 years.	
c. May petition the MPSC for and receive approval	
d. A preliminary interview before the Committee shall be required	

Membership Criteria	Yes
10. Pediatric Nephrology Fellowship (3 years)	
a. Fellowship training program accredited by the ACGME RRC-Ped	
b. Transplant program at which training takes place performs an average of at least 10 pediatric kidney transplants per year.	
c. Involved with 10 or more pediatric kidney transplant recipients	
d. Followed 30 patients a minimum of 6 months from the time of their transplant	
e. Experience with pre-, peri-, and post-operative care of 10 pediatric kidney transplants	
f. Observed 3 organ procurement procedures and 3 kidney transplants	
g. Observed the evaluation of the donor and donor process and management of at least 3 multiple organ donors that include the kidney	
11. Transplant Medicine Fellowship – <i>for board certified or eligible Pediatric Nephrologists</i>	
a. Involved with 10 or more pediatric kidney transplants	
b. Followed 30 patients a minimum of 6 months post-transplant	
c. Experience with pre-, peri-, and post-operative care of 10 pediatric kidney transplants	
d. Observed 3 organ procurement procedures and 3 kidney transplants	
e. Observed the evaluation of the donor and donor process and management of at least 3 multiple organ donors that include the kidney.	
12. Pediatric - Combined Training/Experience - <i>for board certified or eligible Pediatric Nephrologists</i>	
a. Two or more years experience (gained during or after fellowship or as an accumulation during both periods)	
b. Involved in the primary care of 10 or more kidney transplants on pediatric patients (including pre-, peri-, and post-operative care)	
c. Followed 30 patients a minimum of 6 months post-transplant	
d. Observed 3 organ procurement procedures and 3 kidney transplants	
e. Observed the evaluation of the donor and donor process and management of at least 3 multiple organ donors that include the kidney.	
13. Conditional Pathway – <i>Only available to Existing Programs</i>	
a. Center conducts 60 or more kidney transplants per year	
b. Physician provides Primary care for 15 or more kidney transplants recipients from the time of their transplant.	
c. Minimum of 12 months on an active kidney transplant service acquired over a maximum of 2 years.	
d. Consulting relationship with counterparts at another approved kidney transplant center. (include letter of support)	

- k) 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	
Pre- and Post-Operative Care	
Post-Operative Immunosuppressive Therapy	
Long-term Outpatient Follow-up	
Care of Acute and chronic kidney failure	
Donor Selection	
Recipient Selection	
Histologic interpretation of allograft biopsies and interpretation of ancillary tests for renal dysfunction	
Care of Living Donors (if applicable)	
Additional Information	

- l) Describe the proposed primary physician's transplant training and experience in the areas listed below. Individuals certified in pediatric nephrology should address these areas as they pertain to the pediatric kidney candidate/recipient. (Expand rows as necessary)

Experience and Training	Description of Individual's current working knowledge in the these areas
Candidate Evaluation Process	
Pre- and Post-Operative Care	
Post-Operative Immunosuppressive Therapy	
Long-term Outpatient Follow-up	
Care of Acute and chronic kidney failure	
Donor Selection	
Recipient Selection	
Histologic interpretation of allograft biopsies and interpretation of ancillary tests for renal dysfunction	
Candidate Evaluation Process	
Fluid and electrolyte management (Peds only)	
Effects of transplantation and immunosuppressive agents on growth and development (Peds only)	

Experience and Training	Description of Individual's current working knowledge in the these areas
Manifestation of rejection in the pediatric patient (Peds only)	
Care of Living Donors (if applicable)	
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/Other 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
	3,C, 2,a	Current C.V.
	3,C, 2,c	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.
	3,C, 2,d,f, & g	A letter from the Physician detailing his/her commitment to the program and level of involvement in substantive patient care.

a) Name: _____

b) This physician participates in (check all that apply):

Active Yes/No		Type	
		Additional	Other
	Kidney Transplantation		
	Care of Living Kidney Donors		

c) 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. Also, include an explanation that describes the scope of privileges.

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

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 kidney 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	# KI Pts. Followed:		
			Pre	Peri	Post

- g) Transplant Experience (Post fellowship only): List the name of institution(s), applicable dates, and the number of kidney transplants performed at the institution for which 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	# KI Pts. Followed:		
			Pre	Peri	Post

- h) Describe in detail the transplant physician's involvement in this kidney transplant program. (Expand rows as necessary)

Areas of Involvement in this program	Description
Candidate Evaluation Process	
Pre- and Post-Operative Care	
Post-Operative Immunosuppressive Therapy	
Long-term Outpatient Follow-up	
Care of Acute and chronic kidney failure	
Donor Selection	
Recipient Selection	
Histologic interpretation of allograft biopsies and interpretation of ancillary tests for renal dysfunction	
Care of Living Donors (if applicable)	
Additional Information	

- i) Describe the physician's transplant training and experience in the role of transplant patient management in the areas listed below. Individuals certified in pediatric nephrology should address these areas as they pertain to the pediatric kidney candidate/recipient. (Expand rows as necessary).

Areas of Involvement in this program	Description
Candidate Evaluation Process	
Pre- and Post-Operative Care	
Post-Operative Immunosuppressive Therapy	
Long-term Outpatient Follow-up	
Care of Acute and chronic kidney failure	
Donor Selection	
Recipient Selection	
Histologic interpretation of allograft biopsies and interpretation of ancillary tests for renal dysfunction	
Fluid and electrolyte management (Peds only)	
Effects of transplantation and immunosuppressive agents on growth and development (Peds only)	
Manifestation of rejection in the pediatric	

Areas of Involvement in this program	Description
patient (Peds only)	
Care of Living Donors (if applicable)	
Additional Information	

Part 4 Living Donor Transplantation

Complete this section only if submitting an application for living donor transplantation.

It is recognized that in the case of pediatric living donor transplantation, the living organ donation may occur at a center that is distinct from the approved transplant center. If this program performs pediatric transplants, please list any other hospitals where the donation may occur.

Hospital Name	Location

Part 4A Personnel – Primary Renal Donor Surgeon – Open Nephrectomy

(The laparoscopic and open donor nephrectomy expertise may reside within the same or different individuals.)
Refer to the Bylaws for the necessary qualifications and provide the following documents:

Check list	Question Reference	Required Supporting Documents
	4,A,1	Current C.V.
	4,A,1,d	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.
	4,A,1,c, e, & f	Letter from the Surgeon detailing his/her commitment to the program and describing their previous experience/training.
	4,A,1,e & i	ASTS Certificate in Kidney (as applicable)
	4,A,1,g	Log of nephrectomies (complete Table 6)

1. Name: _____

- a) This surgeon participates in ____ Open Nephrectomies ____ Laparoscopic Nephrectomies (Check all that apply)
- b) Date of Appointment (MM/DD/YY): Facility: ____ To this position: ____
- c) Percentage of professional time spent at this facility: _____% = ____ hrs/week
- d) 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.
- e) Experience/ Training
 - i) Qualifying by ASTS Fellowship with a certificate in Kidney

	Yes	No
Did this individual complete an accredited ASTS Fellowship with a certificate in Kidney?		
If “Yes,” complete the questions below and provide a copy of the Certificate.		
Institution: _____		
Fellowship Program Director: _____		
Date of training: mm/dd/yy format): Start _____ End: _____		

ii) Qualifying by Experience/Training:

	Yes	No
Has this individual performed at least 10 open nephrectomies (to include living donor nephrectomy, deceased donor nephrectomy,		

removal of polycystic or diseased kidneys) as the primary surgeon or first assistant, <u>within the prior 5-year period?</u>		
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- f) Complete **TABLE 5** (at the end of this document) summarizing this individuals' training and experience. Include the number of open nephrectomy (and laparoscopic if applicable) cases in which the individual participated as the primary surgeon or first assistant.
- g) Nephrectomy Log: Provide documentation that demonstrates that this individual has experience as the primary surgeon or first assistant in at least 10 open nephrectomies (to include living donor nephrectomy, deceased donor nephrectomy, and removal of polycystic or diseased kidneys) within the prior 5-year period. A blank log for documenting open and laparoscopic living donor nephrectomies has been provided as **TABLE 6** in this application.

Documentation should include the date of the surgery, medical records identification and/or UNOS identification number, the role of the surgeon in the operative procedure, and the type of procedure. A current Procedural Terminology (CPT) code for the procedure is optional but recommended.

- h) Describe the proposed primary donor surgeon's level of involvement in the program for which the application is being made. If applicable, describe the surgeon's plan for coverage of transplant programs located in multiple transplant centers.

- i) Are there other individuals in the program who routinely perform open donor nephrectomies for the living donor program? ___ Yes ___ No. If yes, complete **Part 4C** of this application.

Part 4B Personnel – Primary Renal Donor Surgeon - Laparoscopic Nephrectomy

(The laparoscopic and open nephrectomy expertise may reside within the same or different individuals.)

Refer to the Bylaws for the necessary qualifications and provide the following documents:

Check list	Question Reference	Required Supporting Documents
	4,B,1	Current C.V.
	4,B,1,d	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.
	4,B,1, c,e,f & h	Letter from the Surgeon detailing his/her commitment to the program and describing their previous experience/training.
	4,B,1,g	Log of nephrectomies

1. Name: _____

a) This surgeon participates in ___ Open Nephrectomies ___ Laparoscopic Nephrectomies (Check all that apply)

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

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

d) Does individual have FULL privileges?

_____ 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.

e) Experience/Training:

	Yes	No
Does this individual have experience as the primary surgeon or first assistant in at least 15 laparoscopic nephrectomies (including deceased donor nephrectomy, removal of polycystic or diseased kidneys, etc.), <u>within the prior 5-year period.</u>		

f) Complete **TABLE 5** (within this document) summarizing this individuals training and experience. Include the number of laparoscopic nephrectomies (and open nephrectomy if applicable) cases in which the individual participated as the primary surgeon or first assistant.

- g) Nephrectomy Log: Provide documentation that demonstrates that this individual has experience as the primary surgeon or first assistant in performing at least 15 laparoscopic nephrectomies within the prior 5-year period. A blank log for documenting open and laparoscopic living donor nephrectomies has been provided as **TABLE 6** in this application (duplicate as necessary).

Documentation should include the date of the surgery, medical records identification and/or UNOS identification number, the role of the surgeon in the operative procedure, and the type of procedure. A current Procedural Terminology (CPT) code for the procedure is optional but recommended. It is recognized that in the case of pediatric kidney donor transplantation, the live organ donation may occur at a center that is distinct from the approved transplant center.

- h) Describe the proposed primary donor surgeon's level of involvement in the program for which the application is being made. If applicable, describe the surgeon's plan for coverage of transplant programs located in multiple transplant centers.

- i) Conversion Coverage Plan: If the open and laparoscopic expertise resides within different individuals, then the program must document how both individuals will be available to the surgical team. Describe how the center will handle surgical decisions and coverage for the laparoscopic to open conversion.

- j) Are there other individuals in the program who also perform laparoscopic nephrectomies for the living donor program? ___ Yes ___ No. If yes, complete **Part 4C** of this application:

Part 4C Personnel – Renal Donor Surgeons

Open and Laparoscopic Donor Nephrectomy Surgeons. Complete this section for each surgeon, other than the designated primary(ies) who will be performing living donor nephrectomies at this center. Provide the following documents:

Check list	Question Reference	Required Supporting Documents
	4C,1	Current C.V.
	4C,1,d	Letter from the Credentialing Committee of the applicant hospital stating that the surgeon meets all requirements to be in good standing. Provide an explanation of any status other than active/full.
	4C,1,c,e,& f	Letter from the Surgeon detailing his/her commitment to the program and describing their previous experience/training.

1. Name: _____

- a) This surgeon participates in ____ Open Nephrectomies ____ Laparoscopic Nephrectomies (Check all that apply)
- b) Date of Appointment (MM/DD/YY): Facility: _____ To this position: _____
- c) Percentage of professional time spent at this facility: _____% = _____ hrs/week
- d) 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.
- e) Complete **TABLE 5** (at the end of this document) summarizing this individuals training and experience. Include the number of open nephrectomy and laparoscopic cases in which the individual participated as the primary surgeon or first assistant.
- f) Describe the donor surgeon's level of involvement in the program for which the application is being made.

Part 4D - Other Staff and Resources

Complete this section only if applying for initial approval for living donor kidney transplantation.

1. How does the center assess that the short and long term risks for the potential living donor are acceptable to the medical staff at the transplant center and the donor? Response needs to address the following: evaluation, consent, surgical risk, and long-term donor considerations for being made uninephric.

2. Mental Health and Social Support Services: Identify the designated members of the transplant team who have primary responsibility for coordinating the psychosocial needs of living donors. Describe their role in this process (expand rows as needed).

Name	Role in Providing Support to Living Donors

Does the program have the ability to perform a psychosocial assessment of the donor to

- make an informed decision? Yes ____ No ____
- affirm voluntary nature of proceeding with the evaluation and donation? Yes ____ No ____

3. Describe how the program meets the requirement for having an Independent Donor Advocate (IDA) who is not involved with the potential recipient evaluation and is independent of the decision to transplant the potential recipient.

Part 4E - Protocols:

1. Kidney transplant programs that perform living donor kidney transplants must demonstrate that they have the following listed below. Submission of protocols is not required as a part of this application.

Written protocols must address at a minimum the areas listed below:	Included in Protocol?	
	Yes	No
Protocols addressing all phases of living donation process: <ul style="list-style-type: none"> • Evaluation • Pre-operative • Operative • Post-operative care • Submission of follow up forms. 		
IDA – descriptions of duties and responsibilities: Include the following elements: <ul style="list-style-type: none"> • promotes the best interests of the potential living donor; • advocates the rights of the potential living donor; and • assists the potential donor in obtaining and understanding information regarding the consent process; evaluation process; surgical procedure; and benefit and need for follow-up. 		
Medical Evaluation by a physician and/or surgeon experienced in living donation to assess and minimize risks to the potential donor post-donation, which shall include a screen for any evidence of occult renal and infectious disease and medical co-morbidities, which may cause renal disease.		
Psychosocial Evaluation of the potential living donor by a psychiatrist, psychologist, or social worker with experience in transplantation to <ul style="list-style-type: none"> • determine decision making capacity, • screen for any pre-existing psychiatric illness, and • evaluate any potential coercion. 		
Screening for evidence of transmissible diseases such as cancers and infections; and		
Anatomic assessment of the suitability of the organ for transplant purposes.		
Informed Consent for Donor Evaluation Process and Donor Nephrectomy: <ul style="list-style-type: none"> • discussion of the potential risks of the procedure including the medical, psychological, and financial risks associated with being a living donor; • assurance that all communication between the potential donor and the transplant center will remain confidential; • discussion of the potential donor’s right to opt out at any time during the donation process; • discussion that the medical evaluation or donation may impact the potential donor’s ability to obtain health, life, and disability insurance; and • disclosure by the transplant center that it is required, at a minimum, to submit Living Donor Follow-up forms addressing the health information of each living donor at 6 months, one-year, and two-year post donation. The protocol must include a plan to collect the information about each donor. 		

2. How will the center assess its compliance with each protocol listed above?

PART 5: 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 Proposed Primary Surgeon:

Date:

Print name:

Signature of Proposed Primary Physician:

Date:

Print name:

* additional rows may be added as necessary.

Part 6: OPTN Staffing Report

KIDNEY 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 UNETsm and the Membership Directory, make sure to include the best (most accurate) telephone number and address for each person. Check “D” and/or “L” to specify each individual’s involvement with deceased donor liver transplantation, living donor liver transplantation, or both as applicable. Add additional rows as necessary.

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

Name	L	D	Address	Phone	Fax	Email

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

Name	L	D	Address	Phone	Fax	Email

List the **Donor Surgeons** who participate in living donation (only):

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	L	D	Address	Phone	Fax	Email

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

Name	L	D	Address	Phone	Fax	Email

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

Name	L	D	Address	Phone	Fax

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

Name	L	D	Address	Phone

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

Name	L	D	Address	Phone

List the **Independent Donor Advocate(s) (IDA)** who participate in the care of Living Donors (complete only if application includes living donor transplantation):

Name	Address	Phone	Fax	Email

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

Name	L	D	Address	Phone

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

Name	L	D	Address	Phone

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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25				
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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			
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33			
34			
35			

Director’s Signature: _____

Date: _____

Extend lines on log as needed

TABLE 4 Primary Physician Log (2) (Sample)

(Header should include the following information. 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				

TABLE 5 – Primary Donor Surgeon(s) - Open and Laparoscopic Nephrectomies
SUMMARY OF EXPERIENCE AND TRAINING FOR DR. _____

List each institution on a separate row.

This summary must document (at a minimum) that the individual:

- 1) performed no fewer than 10 open nephrectomies (to include living donor nephrectomy, deceased donor nephrectomy, and removal of polycystic or diseased kidneys) as primary surgeon or first assistant within the prior 5-year period; and/or
- 2) acted as primary surgeon or first assistant in performing no fewer than 15 laparoscopic nephrectomies within the prior 5-year period.

Periods of training and post-fellowship experience must be listed on separate rows.

Date From To mm/dd/yy	Institution	Program Director	# Open Nephrectomies as Primary	# Open Nephrectomies as 1st Assistant	#Laparoscopic Nephrectomies as Primary	# Laparoscopic Nephrectomies as 1st Assistant

The numbers entered above should be validated by the attached log.
 Insert additional rows as needed.

TABLE 6 - Primary Donor Surgeon - Nephrectomy Log

(Header should include the following information. Cases should be listed by type then date order)

Application Type: ___ Open Nephrectomy ___ Laparoscopic Nephrectomy (Check all that apply)

Name of Proposed Primary Donor Surgeon:	
Name of transplant center where he/she was working when the nephrectomies were performed:	

This log must document (at a minimum) that the individual:

- 1) performed at least 10 open nephrectomies (to include living donor nephrectomy, deceased donor nephrectomy, and removal of polycystic or diseased kidneys) as primary surgeon or first assistant within the prior 5-year period; and/or
- 2) acted as primary surgeon or first assistant in performing at least 15 laparoscopic nephrectomies within the prior 5-year period.

Applicable CPT codes are listed on the next page.

#	Date of Nephrectomy	Donor ID Number	Nephrectomy site (hospital)	Procedure (Check Type)		CPT Code (Optional)
				Open	Laparoscopic	
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						

Insert additional rows as needed.

Director's Signature: _____

Date: _____

Applicable CPT Codes

Open Donor Nephrectomy:

- 50220 Remove kidney, open
- 50225 Removal kidney open, complex
- 50230 Removal kidney open, radical
- 50234 Removal of kidney & total ureter and bladder cuff, through same incision
- 50236 Removal of kidney & ureter through separate incision
- 50300 Removal of donor kidney (Cadaver donor, unilateral or bilateral)
- 50320 Removal of donor kidney (open)
- 50340 Removal of recipient kidney

Laparoscopic Nephrectomy:

- 50545 Laparo radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy)
- 50546 Laparoscopic nephrectomy including partial ureterectomy
- 50547 Laparo removal donor kidney (including cold preservation), from living donor
- 50549 Laparoscope proc, renal