PART 3: Liver Transplant Program
Including Programs Performing Living Donor Liver Transplantation

This application is for (check all that apply):

	Liver Transplantation	Living Donor Liver Transplantation
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 liver transplant program (include C.V.). Briefly describe the leadership responsibilities for each individual, including their role in living donor liver 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, Sections 1 & 2: Personnel – Surgical – Primary Surgeon(s)

1. **Primary Liver and/or Living Donor Liver 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 1,a	Current C.V.
	3,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.
	3B 1e,h,i	Letter from the Surgeon detailing his/her commitment to the program and describing their transplant training/experience
	3,B, 1,h	Formal Training: A letter from the training director verifying that the fellow has met the requirements
	3,B, 1,h	Formal Training: Log(s) (organized by date) of the transplant and procurement procedures
	3,B, 1,i	Transplant Experience: A letter from the program director verifying that the individual has met the primary surgeon requirements and is qualified to direct a liver transplant program
	3,B, 1,i	Transplant Experience: Log(s) (organized by date) of the transplant and procurement procedures
	3,B, 1,m	Living Donor Liver Experience: A log (organized by date) of major hepatic resection surgeries and living donor hepatectomies performed within the past 5 years. **Required only for programs performing or seeking to perform living donor liver transplantation or for changes in the primary living donor liver transplant surgeon(s).**
	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 individual is being proposed as (check all that apply):

	Primary Liver Transplant Surgeon
	Primary Living Donor Liver Transplant Surgeon (must complete question c) below)

c) **Living Donor Liver applicants only:**
Is this individual currently designated as the OPTN primary liver transplant surgeon for the liver transplant program at this hospital? _____ Yes _____ No.

If Yes, supply the documents requested in lines 1, 2, 3, 8 and 10 of the checklist above and answer questions j) and m) below. If "No," complete questions d) through m) below. **NOTE: If the individual is being proposed simultaneously as the primary liver transplant surgeon and one of the two primary living donor liver transplant surgeons, all questions in this section must be answered and all required supporting documentation must be submitted.**

d)
Date of employment at this hospital (MM/DD/YY): _____
Date assumed role of primary surgeon (MM/DD/YY): _____

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) Percentage of professional time spent at this hospital: _____% = _____ hrs/week.

f) 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

g) 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	Certificate Effective Date (MM/DD/YY)	Certificate Valid through Date (MM/DD/YY)	Certification Number

h) Transplant Training (Fellowship): List the name of the transplant hospital(s) at which liver transplant training (fellowship) was received. Include the program director(s) names, applicable dates, and the number of transplants performed. If the surgeon is qualifying as the primary surgeon through fellowship training also submit the supporting documents listed below. Refer to the Bylaws for the necessary qualifications and descriptions of the required supporting documents.

- A letter from program director verifying that the fellow has met the requirements.
- Logs (see Tables 4A and 4B) 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	**Transplant Hospital**	**Program Director**	**# LI Transplants as Primary**	**# LI Transplants 1st Assisted**	**# of LI Procureme as Primary 1st Assista**

i) Transplant Experience (Post fellowship): List the name of the transplant hospital(s), program director name(s), applicable dates, and number of liver transplants performed by the individual at each transplant hospital. 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.
- Log (see Tables 4A and 4B) 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).
  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	**Transplant Hospital**	**Program Director**	**# LI Transplants as Primary**	**# LI Transplants 1st Assisted**	**# of LI Procurements as Primary or 1st Assistant**

j) 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 Surgery, or the foreign equivalent	
3. Two-year liver transplant fellowship	
a. Primary surgeon or 1st assistant on at least 45 liver transplants	
b. Primary surgeon or 1st assistant on at least 20 liver procurements of which at least 3 include the selection and management of the donor	
c. Involved in all levels of pre-, peri-, and post-operative patient care within the last 2 years	
4. Experience (Post Fellowship)	

Membership Criteria	Yes
a. Primary surgeon or 1st assistant on 60 or more liver transplants over a minimum of 2 years and a maximum of 5 years	
b. Primary surgeon or 1st assistant on at least 30 liver procurement procedures of which 3 include selection and management of the donor	
c. Involved in all levels of pre-, peri-, and post-operative patient care within the last 2 years	
5. Pediatric Pathway	
a. Program serves predominantly pediatric patients	
b. Individual has maintained current working knowledge in all aspects liver transplantation and patient care within the last 2 years.	
c. Hospital has petitioned the Membership and Professional Standards Committee (MPSC) for approval	
d. A preliminary interview before the Membership and Professional Standards Committee shall be required	
6. Living Donor Liver Experience – Criteria for Full Approval	
a. Primary surgeon or 1st assistant on 20 major hepatic resection surgeries, including at least 7 living donor hepatectomies, within the past 5 years	
7. Living Donor Liver Experience – Criteria for Conditional Approval	
a. Primary surgeon or 1st assistant on 20 major hepatic resection surgeries within the past 5 years	

k) 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 hospitals. (Expand rows below as necessary and use complete sentences (i.e. narrative descriptions) for each).

	Describe Involvement
Management of patients with end stage liver disease	
Recipient selection	
Donor selection	
Histocompatibility and tissue typing	
Transplant surgery	
Post-operative and continuing inpatient care	
Use of immunosuppressive therapy	
Differential diagnosis of liver allograft dysfunction	
Histologic interpretation of allograft biopsies	
Interpretation of ancillary tests for liver dysfunction	
Long term outpatient care	
Coverage of multiple transplant hospitals (if applicable)	
Living Donor Transplantation (if applicable)	
Additional Information	

l) Describe the proposed primary surgeon's transplant training and experience in the areas listed below. (Expand rows below as necessary and use complete sentences (i.e. narrative descriptions) for each).

	Describe Training/Experience
Management of patients with end stage liver disease	
Recipient selection	
Donor selection	
Histocompatibility and tissue typing	
Transplant surgery	
Post-operative and continuing inpatient care	
Use of immunosuppressive therapy	
Differential diagnosis of liver allograft dysfunction	
Histologic interpretation of allograft biopsies	
Interpretation of ancillary tests for liver dysfunction	
Long term outpatient care	
Additional Information	

m) Living donor liver applicants only:

Provide documentation (complete Table 4C) that demonstrates that this individual has experience as the primary surgeon or first assistant in 20 major hepatic resection surgeries, including at least 7 living donor hepatectomies, within the past 5 years.

These cases must be documented. 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, the type of procedure and the current Procedural Terminology (CPT) code for the procedure. . A blank log for documenting these procedures has been provided at the end of this application (Table 4C). It is recognized that in the case of pediatric living donor transplantation, the living organ donation may occur at a hospital that is distinct from the approved transplant hospital.

Please note: When documenting involvement in living donor hepatectomies, be sure to specify that the procedure was performed on the **donor** if the corresponding CPT code is not provided (e.g., left lobectomy – donor).

2. **Primary Living Donor Liver Transplant Surgeon #2.** Complete this section ONLY if applying for approval to perform living donor liver transplantation or a change in key personnel for one of the primary living donor liver transplant surgeons. 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, 2,a	Current C.V.
	3,B, 2,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, 2,d,g & ,h	Letter from the Surgeon detailing his/her commitment to the program and describing their transplant experience/training
	3,B, 2,g	Formal Training: A letter from the training director verifying that the individual has met the requirements
	3,B, 2,g	Formal Training: Log(s) (organized by date) of the transplant and procurement procedures
	3,B, 2,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 liver transplant program
	3,B, 2,h	Transplant Experience: Log(s) (organized by date) of the transplant and procurement procedures
	3,B, 2,l	Living Donor Liver Experience: Log(s) (organized by date) of major hepatic resection surgeries and living donor hepatectomies performed within the past 5 years. **Required only for programs performing or seeking to perform living donor liver transplantation or for changes in the primary living donor liver transplant surgeon(s).**
	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) Is this individual currently designated as the OPTN primary liver transplant surgeon for the liver transplant program at this hospital? _____ Yes _____ No.
If "Yes," supply the documents requested in lines 1, 2, 3, 8, and 10 of the checklist above and answer questions i) and l) below. If "No," complete questions c) through l) below.

c)
Date of employment at this hospital (MM/DD/YY: _____
Date assumed role of primary surgeons (MM/DD/YY): _____

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 at this hospital: _____% = _____ hrs/week

e) List below the hospitals, health care facilities, and/or 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	Certificate Effective Date (MM/DD/YY)	Certificate Valid through Date (MM/DD/YY)	Certification Number

g) Transplant Training (Fellowship): List the name of the transplant hospital(s) at which liver transplant training (fellowship) was received. Include the program director(s) names, applicable dates, and the number of transplants performed. If the surgeon is qualifying as a primary surgeon through fellowship training also submit the supporting documents listed below. Refer to the Bylaws for the necessary qualifications and descriptions of the required supporting documents

- A letter from program director verifying that the fellow has met the requirements.
- Logs (see Tables 4A and 4B) of the transplant and procurement procedures. The logs should include a medical record/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	**Transplant Hospital**	**Program Director**	**# LI Transplants as Primary**	**# LI Transplants 1st Assisted**	**# of LI Procurements as Primary or 1st Assistant**	

h) Transplant Experience (Post fellowship): List the name of the transplant hospital(s), program director(s) names, applicable dates, and number of liver transplants performed by the individual at each hospital. 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 (see Tables 4A and 4B) of the transplant and procurement procedures. The logs should include a medical record/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	**Transplant Hospital**	**Program Director**	**# LI Transplants as Primary**	**# LI Transplants 1st Assisted**	**# of LI Procurements as Primary or 1st Assistant**	

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 Surgery or the foreign equivalent	
3. Two-year liver transplant fellowship	
a. Primary surgeon or 1st assistant on at least 45 liver transplants	
b. Primary surgeon or 1st assistant on at least 20 liver procurements of which at least 3 include the selection and management of the donor	
c. Involved in all levels of pre-, peri-, and post-operative patient care within the last 2 years	
4. Experience (Post Fellowship)	
a. Primary surgeon or 1st assistant on 60 or more liver transplants over a minimum of 2 years and a maximum of 5 years	
b. Primary surgeon or 1st assistant on at least 30 liver procurement procedures of which 3 include selection and management of the donor	
c. Involved in all levels of pre-, peri-, and post-operative patient care within the last 2 years	
5. Pediatric Pathway	
a. Program serves predominantly pediatric patients	
b. Demonstrate that the individual has maintained current working knowledge in all aspects liver transplantation and patient care within the last 2 years.	
c. The hospital has ppetitioned the Membership and Professional Standards Committee (MPSC) for approval	
d. A preliminary interview before the Membership and Professional Standards Committee shall be required	
6. Living Donor Liver Experience – Criteria for Full Approval	
a. Primary surgeon or 1st assistant on 20 major hepatic resection surgeries, including at least 7 living donor hepatectomies, within the past 5 years	
7. Living Donor Liver Experience – Criteria for Conditional Approval	
a. Primary surgeon or 1st assistant on 20 major hepatic resection surgeries within the past 5 years.	

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 hospitals. (Expand rows below as necessary and use complete sentences (i.e. narrative descriptions) for each).

	Describe Involvement
Management of patients with end stage liver disease	
Recipient selection	
Donor selection	
Histocompatibility and tissue typing	
Transplant surgery	
Post-operative and continuing inpatient care	
Use of immunosuppressive therapy	
Differential diagnosis of liver allograft dysfunction	
Histologic interpretation of allograft biopsies	
Interpretation of ancillary tests for liver dysfunction	
Long term outpatient care	
Coverage of multiple transplant hospitals (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 and use complete sentences (i.e. narrative descriptions) for each).

	Describe Training/Experience
Management of patients with end stage liver disease	
Recipient selection	
Donor selection	
Histocompatibility and tissue typing	
Transplant surgery	
Post-operative and continuing inpatient care	
Use of immunosuppressive therapy	
Differential diagnosis of liver allograft dysfunction	
Histologic interpretation of allograft biopsies	
Interpretation of ancillary tests for liver dysfunction	
Long term outpatient care	
Additional Information	

l) Provide documentation (complete Table 4C) that demonstrates that this individual has experience as the primary surgeon or first assistant in 20 major hepatic resection surgeries, including at least 7 living donor hepatectomies, within the past 5 years.

These cases must be documented. 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, the type of procedure and a current Procedural Terminology (CPT) code for the procedure. A blank log for documenting these procedures **(Table 4C)** has been provided at the end of this application. It is recognized that in the case of pediatric living donor transplantation, the living organ donation may occur at a hospital that is distinct from the approved transplant hospital.

Please note: When documenting involvement in living donor hepatectomies, be sure to specify that the procedure was performed on the **donor** if the corresponding CPT code is not provided (e.g., left lobectomy – donor).

Additional Instructions for PART 3B, Section 3: Personnel – Additional/Other Surgeons

Complete this section of the application to describe the involvement, training, and experience of other surgeons associated with the program. Surgeons must be designated as **Additional** or **Othe**r as described below.

All surgeons must be listed in Table 1 (Certificate of Investigation) in this application.

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 3: Personnel – Additional/ Other Surgeons

3. Additional and Other Surgeons (Duplicate this section as needed). Provide the attachments listed below.

Check list	Question Reference	Required Supporting Documents
	3,B, 3,a	Current C.V.
	3,B, 3,c	A letter from the Credentialing Committee of the applicant hospital stating that each surgeon meets all requirements to be in good standing. Please provide an explanation of any status other than active/full
	3,B,3,d,f, & g	A letter from each 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):

	Type	
	Additional	Other
Liver Transplantation		
Living Donor Liver Transplantation		

c)

Date of employment at this hospital (MM/DD/YY): _____

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	Certificate Effective Date (MM/DD/YY)	Certificate Valid through Date (MM/DD/YY)	Certification Number

f) Transplant Training (Fellowship): List the name of the transplant hospital(s) at which liver transplant training (fellowship) was received. Include program director(s) names, applicable dates, and the number of transplants the individual performed.

Date From – To MM/DD/YY	**Transplant Hospital**	**Program Director**	**# LI Transplants as Primary**	**# LI Transplants 1st Assisted**	**# of LI Procurements as Primary or 1st Assistant**	

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

Date From – To MM/DD/YY	**Transplant Hospital**	**Program Director**	**# LI Transplants as Primary**	**# LI Transplants 1st Assisted**	**# of LI Procurements as Primary or 1st Assistant**	

h) Describe the surgeon's level of involvement in this liver transplant program in the areas listed below. (Expand rows as necessary and use complete sentences (i.e. narrative descriptions) for each).

	Describe Involvement
Management of patients with end stage liver disease	
Recipient selection	
Donor selection	
Histocompatibility and tissue typing	
Transplant surgery	
Post-operative and continuing inpatient care	
Use of immunosuppressive therapy	
Differential diagnosis of liver allograft dysfunction	
Histologic interpretation of allograft biopsies	
Interpretation of ancillary tests for liver dysfunction	
Long term outpatient care	
Living donor transplantation (if applicable)	
Additional Information	

i) Describe the surgeon's liver transplant training and experience in the areas listed below. (Expand rows as necessary and use complete sentences (i.e. narrative descriptions) for each).

	Describe Training/Experience
Management of patients with end stage liver disease	
Recipient selection	
Donor selection	
Histocompatibility and tissue typing	
Transplant surgery	
Post-operative and continuing inpatient care	
Use of immunosuppressive therapy	
Differential diagnosis of liver allograft dysfunction	
Histologic interpretation of allograft biopsies	
Interpretation of ancillary tests for liver dysfunction	
Long term outpatient care	
Additional Information	

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

1. **Primary Liver 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 individual has met the requirements.
	3,C, 1,g	Formal Training: Log(s) (organized by date) of the transplant patients followed.
	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: Llog(s) (organized by date) of the transplant patients followed.
	3C	Other Letters of Recommendation (Reference)
	5a	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) Does this individual participate in the care of living liver donors? _____ Yes _____ No
Is this individual currently designated as the OPTN primary liver transplant physician for the liver transplant program at this hospital? _____ Yes _____ No.
If "Yes," supply the documents requested in lines 1, 2, 3 and 9 of the checklist above and answer question j) below. If "No," complete questions c) through l) below.

c) Date of Appointment (MM/DD/YY): Facility: _____ To this position: _____
Date of employment at this hospital (MM/DD/YY): _____
Date assumed role of primary physician (MM/DD/YY): _____

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 on site: _____% = _____ hrs/week

e) List other hospitals, health care facilities, and/or 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	Certificate Effective Date (MM/DD/YY)	Certificate Valid through Date (MM/DD/YY)	Certification Number

g) Transplant Training (Fellowship): List the program(s) at which liver transplant training was received. Include the name of the transplant hospital(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). If the physician is qualifying as the primary physician through fellowship training also submit the supporting documents listed below:

Refer to the Bylaws for the necessary qualifications and descriptions of the required supporting documents.

- Letters from the director of fellowship training program and the supervising physician verifying that the fellow has met the requirements.
- Recipient logs (see Table 4D) 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	Transplant Hospital	Program Director	# Liver Patients Followed		
			Pre	Peri	Post

h) Transplant Experience (Post fellowship only): List the name of the transplant hospital(s), program director name(s), applicable dates, and number of liver transplants performed at the transplant hospital 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.

- Supporting letter(s) from the qualified liver transplant physician and/or liver transplant surgeon with whom the proposed primary physician has previously worked.
- Recipient log (see Table 4D) that includes the date of transplant and the patient's medical record 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	Transplant Hospital	Program Director	# Liver Patients Followed		
			Pre	Peri	Post

i) TransplantTraining/Experience. Describe how the physician fulfills the criteria for participating as an observer in 3 multiple organ procurements and 3 transplants that include the liver, as well as observing the evaluation of the donor and donor process, and management of at least 3 multiple organ donors which include the liver.

- Provide a log (Complete Table 4E) 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	Transplant Hospital	# of LI Procurements Observed	# of LI Transplants Observed	# of LI Donors/ Donor Process	# of Multi-Organ Donors Observed Mgmt.

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

Membership Criteria	Yes
1. On site	
2. M.D., D.O. or equivalent degree from another country	
3. Certified in Gastroenterology by the American Board of Internal Medicine, American Board of Pediatrics or the foreign equivalent	
4. Direct involvement in liver transplant patient care within the last 2 years.	
5. Transplant Hepatology Fellowship	
a. Participated in 12 month transplant hepatology fellowship	
b. Participated in primary care of 30 or more liver transplant recipients for a minimum of 3 months from the time of their transplant	
c. Observed 3 organ procurement procedures and 3 liver transplants	
d. Observed the evaluation of the donor and donor process and management of at least 3 multiple organ donors that include the liver	
6. Experience in Liver transplantation (Post Fellowship)	
a. 2-5 years experience on an active liver transplant service	
b. Participated in the primary care of 50 or more liver transplant recipients for a minimum of 3 months from the time of their transplant over a 2-5 year period	
c. Observed 3 organ procurement procedures and 3 liver transplants	
d. Observed the evaluation of the donor and donor process and management of at least 3 multiple organ donors that include the liver	
7. Pediatric Gastroenterology Fellowship (3 years)	
a. Fellowship training program accredited by the ACGME RRC-Ped	

Membership Criteria	Yes
b. Transplant program at which training takes place performs an average of at least 10 liver transplants on pediatric patients per year.	
c. Participated in the primary care of 10 or more pediatric liver transplant recipients	
d. Followed 20 liver transplant recipients for a minimum of 3 months from the time of their transplant	
e. Direct involvement in the pre-, peri-, and post-operative care of 10 or more pediatric liver recipients	
f. Observed 3 organ procurement procedures and 3 liver transplants	
g. Observed the evaluation of the donor and the donor process and management of at least 3 multiple organ donors that include the liver	
8. Transplant Medicine Fellowship – ***for Board-Certified or Eligible Pediatric Gastroenterologists***	
a. Transplant program at which training takes place performs an average of at least 10 liver transplants on pediatric patients per year.	
b. Participated in the primary care of 10 or more pediatric liver transplant recipients	
c. Followed 20 liver transplant recipients for a minimum of 3 months from the time of their transplant	
d. Direct involvement in the pre-, peri-, and post-operative care of 10 or more pediatric liver recipients	
e. Observed 3 organ procurement procedures and 3 liver transplants	
f. Observed the evaluation of the donor and the donor process and management of at least 3 multiple organ donors that include the liver	
9. Combined Training/Experience – ***for Board-Certified or Eligible Pediatric Gastroenterologists***	
a. Two or more years of experience accumulated during fellowship, after fellowship or during both periods at a UNOS-approved liver transplant hospital	
b. Participated in the primary care of 10 or more liver transplants on pediatric patients	
c. Followed 20 liver transplant recipients for a minimum of 6 months from the time of their transplant	
d. Directly involved in the pre-, peri- and post-operative care of 10 or more liver transplants in pediatric patients.	
e. Observed 3 organ procurement procedures and 3 liver transplants	
f. Observed the evaluation of the donor and the donor process and management of at least 3 multiple organ donors that include the liver	
10. Pediatric Pathway	
a. Program serves predominantly pediatric patients	
b. Individual has maintained current working knowledge in all aspects of liver transplantation and patient care within the last 2 years.	
c. Hospital has petitioned the Membership and Professional Standards Committee (MPSC) for approval	
d. A preliminary interview before the Membership and Professional Standards Committee shall be required	
11. 12-month Conditional Pathway - ***Only available to Existing Programs***	
a. Board Certified Gastroenterologist/Hepatologist	
b. Involved in the primary care of 25or more liver transplant recipients for a minimum of 3 months from the time of their transplant	
c. Minimum of 12 months on an active liver transplant service acquired over a maximum of 2 years for individuals qualifying by virtue of acquired clinical experience.	
d. Consulting relationship with counterparts at another approved liver transplant hospital established (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 hospitals. (Expand rows as necessary and use complete sentences (i.e. narrative descriptions) for each).

	Describe Involvement
Management of patients with end stage liver disease	
Care of acute liver failure	
Recipient selection	
Donor selection	
Histocompatibility and tissue typing	
Post-operative and continuing inpatient care	
Use of immunosuppressive therapy	
Differential diagnosis of liver allograft dysfunction	
Histologic interpretation of allograft biopsies	
Interpretation of ancillary tests for liver dysfunction	
Long term outpatient care	
Care of the living liver donor (if applicable)	
Coverage of multiple transplant hospitals (if applicable)	
Care of living donors (as applicable)	
Additional Information	

l) Describe the proposed primary physician's transplant training and experience in the areas listed below. For individuals certified in pediatric gastroenterology, please address these areas as they pertain to the pediatric liver candidate/recipient. (Expand rows as necessary and use complete sentences (i.e. narrative descriptions) for each).

	Describe Training/Experience
Management of patients with end stage liver disease	
Care of acute liver failure	
Recipient selection	
Donor selection	
Histocompatibility and tissue typing	
Post-operative and continuing inpatient care	
Use of immunosuppressive therapy	
Differential diagnosis of liver allograft dysfunction	
Histologic interpretation of allograft biopsies	
Interpretation of ancillary tests for liver dysfunction	
Long term outpatient care	
Fluid and electrolyte management (Peds GI only)	
Effects of transplantation and immunosuppressive agents on growth and development (Peds GI only)	
Manifestation of rejection in the pediatric patient (Peds GI only)	
Additional Information	

Additional Instructions for PART 3C, Section 2: Personnel –Additional/Other Physician(s)

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.

All physicians must be listed in Table 1 (Certificate of Investigation) in this application.

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 as well. The type should be indicated as "Other".

Duplicate pages as needed.

PART 3C, Section 2: Personnel –Additional/Other Physician(s)

2. **Additional and 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, 2a	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):

	Type	
	Additional	Other
Liver Transplantation		
Care of Living Liver Donors		

c)

Date of employment at this hospital (MM/DD/YY): _____

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	Certificate Effective Date (MM/DD/YY)	Certificate Valid through Date (MM/DD/YY)	Certification Number

f) Transplant Training (Fellowship): List the program(s) at which liver transplant training was received. Include the name of the transplant hospital(s), program director(s) names, applicable dates, and the number of transplant patients followed for whom the physician provided substantive care (pre-, peri- and post-operatively from the time of transplant).

Date From To mm/dd/yy	Transplant Hospital	Program Director	# Liver Pts. Followed		
			Pre	Peri	Post

g) Transplant Experience (Post fellowship only): List the name of transplant hospital(s), program director(s) names, applicable dates, and the number of liver transplants performed at the hospital 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	Transplant Hospital	Program Director	# Liver Pts. Followed		
			Pre	Peri	Post

h) Describe in detail the transplant physician's involvement in this liver transplant program. (Expand rows as necessary and use complete sentences (i.e. narrative descriptions) for each).

	Describe Involvement
Management of patients with end stage liver disease	
Care of acute liver failure	
Recipient selection	
Donor selection	
Histocompatibility and tissue typing	
Post-operative and continuing inpatient care	
Use of immunosuppressive therapy	
Differential diagnosis of liver allograft dysfunction	
Histologic interpretation of allograft biopsies	
Interpretation of ancillary tests for liver dysfunction	
Long term outpatient care	
Care of the living liver donor (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. For individuals certified in pediatric gastroenterology, please address these areas as they pertain to the pediatric liver candidate/recipient. (Expand rows as necessary and use complete sentences (i.e. narrative descriptions) for each).

	Describe Training/Experience
Management of patients with end stage liver disease	
Care of acute liver failure	
Recipient selection	
Donor selection	
Histocompatibility and tissue typing	
Post-operative and continuing inpatient care	
Use of immunosuppressive therapy	
Differential diagnosis of liver allograft dysfunction	
Histologic interpretation of allograft biopsies	
Interpretation of ancillary tests for liver dysfunction	
Long term outpatient care	
Fluid and electrolyte management (Peds GI only)	
Effects of transplantation and immunosuppressive agents on growth and development (Peds GI only)	
Manifestation of rejection in the pediatric patient (Peds GI only)	
Care of the living liver donor (if applicable)	
Additional Information	

PART 3D: Living Donor Liver Transplantation

Complete this section ONLY if applying for initial approval for living donor liver transplantation.

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

Hospital Name	Location

PART 3D, Section 1: Other Staff and Resources

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

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 who is independent of the decision to transplant the potential recipient.

Part 3D, Section 2: Living Donor Liver Transplantation – Protocols

1. Liver transplant programs that perform living donor liver recoveries must demonstrate that they have written protocols as listed below. Submission of actual protocol 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: • Evaluation • Pre-operative • Operative • Post-operative care • Submission of follow up forms.		
IDA – descriptions of duties and responsibilities Include the following elements: • 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 liver disease.		
Psychosocial Evaluation of the potential living donor by a psychiatrist, psychologist, or social worker with experience in transplantation to • 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		
Radiographic assessment to ensure adequate anatomy and volume of the donor and of the remnant liver.		
Informed Consent for Donor Evaluation Process and Donor Hepatectomy: • 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 hospital 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 hospital 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-years post donation. The protocol must include a plan to collect the information about each donor. • Documentation of disclosure to donor candidate by the hospital that it is unlawful to sell or purchase human organs.		

2. Describe how the hospital will assess compliance with each protocol listed above. (Use complete sentences).

Table 1: Certificate 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) If yes, what steps are being 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:

*additional rows may be added as necessary

Table 2– Program Coverage Plan

Please answer the questions below and provide a written copy of the current Program Coverage Plan. The plan must be signed by either:

a. the OPTN/UNOS Representative;
b. the Program Director(s); or
c. the Primary Surgeon and Primary Physician.

In accordance with the Bylaws, the program director, in conjunction with the primary transplant surgeon and transplant physician, must submit a written Program Coverage Plan, which documents how 100% medical and surgical coverage is provided by individuals credentialed by the hospital to provide transplant service for the program. A transplant program served by a single surgeon or physician shall inform its patients of this fact and potential unavailability of one or both of these individuals, as applicable, during the year. The Program Coverage Plan must address the following requirements:

	Yes	**No**
Is this a single surgeon program?		
Is this a single physician program?		
If the answer to either one of the above questions is "Yes," explain the protocol for notifying patients.		
Does this transplant program have transplant surgeon(s) and physician(s) available 365 days a year, 24 hours a day, 7 days a week to provide program coverage?		
If the answer to the above question is "No," an explanation must be provided that justifies why the current level of coverage should be acceptable to the MPSC.		
Transplant programs shall provide patients with a written summary of the Program Coverage Plan at the time of listing and when there are any substantial changes in program or personnel. Has this program developed a plan for notification?		
Is a surgeon/physician available and able to be on the hospital premises within one-hour ground transportation time to address urgent patient issues?		
Is a transplant surgeon readily available in a timely manner to facilitate organ acceptance, procurement, and implantation?		
Unless exempted by the MPSC for specific causal reasons, the primary transplant surgeon/primary transplant physician cannot be designated as the primary surgeon/primary transplant physician at more than one transplant hospital unless there are additional transplant surgeons/transplant physicians at each of those facilities. Is this program requesting an exemption? If yes, provide explanation below.		
Additional information:		

Table 3: OPTN Staffing Report

LIVER 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. Check "L" and/or "D" to specify each individual's involvement with living donor liver transplantation, deceased donor liver transplantation, or both as applicable. Add extra rows or use additional pages as necessary. The surgeons and physicians named below should match those listed on the Certificate of Investigation.

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

Name	**L**	**D**	**Address**	**Phone**	**Fax**	**Email**

Identify the **surgeons** who perform transplants . Indicate if they are an "additional" (A) or "other" (O) surgeon in the columns labeled L (Living Donor) and D (deceased donor)

Name	**L**	**D**	**Address**	**Phone**	**Fax**	**Email**

Identify the **physicians** (internists) who participate in this transplant program. Indicate if they are an "additional" (A) or "other" (O) physician in the columns labeled L (Living Donor) and D (deceased donor)

Name	L	D	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 is listed.

Name	L	D	Address	Phone	Fax	Email

Identify the **Financial Counselor(s)** who will be 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	Email

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	Fax	Email

Identify the **Social Worker(s)** and other **Mental Health Professionals** who will be involved with this program:

Name	L	D	Address	Phone	Fax	Email

List the **Independent Donor Advocate(s) (IDA)** who participate in the care of living donors (complete only if applications includes Living Donor Liver transplantation):

Name	Address	Phone	Fax	Email

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

Name	L	D	Address	Phone	Fax	Email

Identify the **Director(s) of Anesthesiology** who will be involved with this program:

Name	L	D	Address	Phone	Fax	Email

TABLE 4A – 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	

Complete a separate form for each transplant hospital.
List cases in date order

#	Date of Transplant	Medical Record/ OPTN 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				

Extend lines on log as needed

Director's Signature: _____ Date: _____

TABLE 4B – Primary Surgeon - Procurement Log (Sample)

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

List cases 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				
18				
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31				
32				
33				
34				
35				

Extend lines on log as needed

Director's Signature: _____ Date: _____

TABLE 4C – Primary Living Donor Liver Surgeon – Log for Living Donor Hepatectomies and other Hepatic Resection Surgeries (Sample) (For Living Donor Liver Applicants Only)

Organ:	
Name of Proposed Primary Surgeon:	
Date range of surgeon's appointment/training: MM/DD/YY to MM/DD/YY	

Log should demonstrate that this individual has experience as the primary surgeon or first assistant in 20 major hepatic resection surgeries, including at least 7 living donor hepatectomies, within the past 5 years.

These cases must be documented. 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, the type of procedure and a Current Procedural Terminology (CPT) code for the procedure It is recognized that in the case of pediatric living donor transplantation, the living organ donation may occur at a hospital that is distinct from the approved transplant hospital.

Please note: When documenting involvement in living donor hepatectomies, be sure to specify that the procedure was performed on the **donor** if the corresponding CPT code is not provided (e.g., left lobectomy – donor).

List cases in date order

#	Date of Surgery	Medical Records/ UNOS ID #	Surgeon Role Primary/ 1st Assistant	Recovery Hospital	Type of surgical procedure	CPT Code (
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						

Extend lines on log as needed

Applicable CPT codes for living donor hepatectomies/major hepatic resections:

Live Donor
47140 Live Donor Hepatectomy (segments II, III - left lateral segment)
47141 Live Donor Hepatectomy (segments II, III, IV -- left lobe)
47142 Live Donor Hepatectomy (segments V, VI, VII, VIII -- right lobe)

Major Hepatic Resections
47120 Hepatectomy (partial lobectomy)
47122 Trisegmentectomy
47125 Total left lobectomy
47130 Total right lobectomy

TABLE 4D – Primary Physician – Recipient Log (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 physician's appointment/training: MM/DD/YY to MM/DD/YY	

Complete a separate form for each transplant hospital.
List cases in date order

#	Date of Transplant	Medical Record/ OPTN ID #	Pre-operative	Peri-operative	Post- Operative (90 days follow up care	Comments
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
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34						
35						

Extend lines on log as needed

Director's Signature: _____ Date: _____

TABLE 4E - Primary Physician – Observation Log (Sample)

Organ:	
Name of Proposed Primary Physician:	
Name of hospital where physician was employed when observations were performed:	
Date range of physician'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)	Liver or Multi-organ?
1				
2				
3				
4				
5				