Part 3: 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):

	Kidney Transplantation
	Living Donor Kidney Transplantation

c)

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

d) Percentage of professional time spent at this hospital : _______% = _____ 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	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 kidney transplant training (fellowship) was received including 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 (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**	**# KI Transplants as Primary**	**# KI Transplants First Assisted**	**# of KI Procurements as Primary or 1st assistant**

h) Transplant Experience (Post fellowship):
List the name of the transplant hospital(s), applicable dates, program director's names, and number of kidney transplants and procurements 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.
- Logs (Tables 4A and 4B) of the transplant and procurement procedures. The log should include a patient identifier/OPTN ID Number, transplant/procurement date, and the surgeon's role in the procedure (i.e., primary or 1st assistant).

Date From – To MM/DD/YY	**Transplant Hospital**	**Program Director**	**# KI Transplants as Primary**	**# KI Transplants First Assisted**	**# of KI 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. 2 year Kidney Transplant Fellowship	
a. Primary surgeon or 1st assistant on at least 30 kidney transplants over the 2 year period	
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 1st 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.	
4. Experience (Post Fellowship)	
a. Primary surgeon or 1st assistant 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 1st assistant on at least 15 kidney procurement procedures. At least 3 of these donors must be multiple organ and at least 10 must be deceased.	
5. Pediatric Pathway	
a. Program serves predominantly pediatric patients	
b. The individual has maintained current working knowledge in all aspects kidney 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	

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 and use complete sentences (i.e. narrative descriptions) for each).

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

PART 3B, Section 2: Personnel –Additional/Other Surgeons

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**. 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 2: Personnel – Additional/Other Surgeons

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):

	Type	
	Additional	Other
Kidney Transplantation		
Living Donor Kidney 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 kidney transplant training (fellowship) was received. Include program director(s) names, applicable dates, and the number of transplants and procurements the individual performed.

Date From – To MM/DD/YY	Transplant Hospital	Program Director	# KI Transplants as Primary	# KI Transplants First Assisted	# of KI 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 kidney transplants and procurements performed by the individual at each hospital.

Date From – To MM/DD/YY	Transplant Hospital	Program Director	# KI Transplants as Primary	# KI Transplants First Assisted	# of KI Procurements as Primary or 1st assistant

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

	Describe 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 and use complete sentences (i.e. narrative descriptions) for each).

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

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

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

Facility	Type	Location (City, State)	% Professional Time Spent on Site

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

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

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

If the physician is qualifying as 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 the fellowship training program and the supervising physician verifying that the fellow has met the requirements.
- Recipient log(s) (see Table4C) that includes the date of transplant, and 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**	**# KI Patients Followed:**		
			Pre	**Peri**	**Post**

g) Transplant Experience (Post fellowship only): List the name of the transplant hospital(s), program director name(s), applicable dates, and the number of kidney transplant patients 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). 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 Table4C) 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	**Transplant Hospital**	**Program Director**	**# KI Patients Followed:**		
			Pre	**Peri**	**Post**

h) Training/Experience. Describe how the physician fulfills the criteria for participatiing as an observer in 3 multiple organ procurements and 3 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 4D.
- If these criteria 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**

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

Membership Criteria	**Yes**
1. On site	
2. M.D., D.O. or equivalent degree	
3. Certified by the American Board of Internal Medicine, Pediatrics or the foreign equivalent	
4. Board certified in Nephrology	
5. 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	
6. 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	
7. 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 Membership and Professional Standards Committee (MPSC) for and receive approval	
d. A preliminary interview before the Membership and Professional Standards Committee shall be required	
8. Pediatric Nephrology Fellowship (3 years)	

Membership Criteria	Yes
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	
9. Transplant Medicine Fellowship – *for board certified or eligible Pediatric Nephrologists*	
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.	
10. Pediatric - Combined Training/Experience - *for board certified or eligible Pediatric Nephrologists*	
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.	
11. Conditional Pathway – ***Only available to Existing Programs***	
a. Center conducts 60 or more kidney transplants per year	
b. Physician provides Primary care for 23 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)	

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

	Describe Involvement
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	

k) 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, and use complete sentences (i.e. narrative descriptions) for each).

	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)	
Manifestation of rejection in the pediatric patient (Peds only)	
Care of Living Donors (if applicable)	
Additional Information	

PART 3C, Section 2: Personnel – Additional/Other 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**.
All physicians must be listed on 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 of the application. The type should be indicated as "other."

Duplicate pages as needed

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

	Type	
	Additional	Other
Kidney Transplantation		
Care of Living Kidney 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. 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	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 kidney transplant training was received including name of transplant hospital(s). Include the program director(s) names, applicable dates, and the number of kidney transplant patients 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	# KI Pts. Followed:		
			Pre	Peri	Post

g) Transplant Experience (Post fellowship only): List the name of transplant hospital(s), applicable dates, and the number of kidney transplant patients 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	# KI Pts. Followed:		
			Pre	Peri	Post

h) Describe in detail the transplant physician’s involvement in this kidney transplant program. (Expand rows as necessary**, use complete sentences (i.e. narrative descriptions) for each).**

Areas of Involvement in this program	**Describe Involvement**
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, use complete sentences (i.e. narrative descriptions) for each).

Areas of Involvement in this program	**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	
Fluid and electrolyte management (Peds only)	
Effects of transplantation and immunosuppressive agents on growth and development (Peds only)	
Manifestation of rejection in the pediatric patient (Peds only)	
Care of Living Donors (if applicable)	
Additional Information	

Part 3D: Living Donor Kidney Transplantation

Complete this section only if submitting a new application for living donor kidney transplantation.

It is recognized that in the case of pediatric living donor transplantation, the living organ donation may occur at a transplant hospital that is distinct from the approved transplant center. 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 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 Table4F)

1. Name: ____

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

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

c) Percentage of professional time spent supporting living kidney transplantation: _______% = _____ 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.		
Transplant hospital:		
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 (living donor nephrectomies, deceased donor nephrectomies, and/or removal of polycystic or diseased kidneys) as the primary surgeon or first assistant within the past 5 years?		

f) Complete **TABLE 4E** (at the end of this document) summarizing this individual's training and experience. Include the number of open nephrectomies (and laparoscopic if applicable) in which the individual participated as the primary surgeon or first assistant.

g) Donor Recovery Log: Provide documentation that demonstrates that this individual has experience as the primary surgeon or first assistant in at least 10 open nephrectomies (living donor nephrectomies, deceased donor nephrectomies, and/or removal of polycystic or diseased kidneys) within the past 5 years. A blank log for documenting open and laparoscopic living donor nephrectomies has been provided as **TABLE 4F** 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 included.

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.

Part3D, Section 2 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 employment at this hospital (MM/DD/YY)?: ______________
   Date assumed role of primary physician (MM/DD/YY)?: ______________

   c) Percentage of professional time spent supporting living kidney transplantation: _______% = _____ 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 (living donor nephrectomies, deceased donor nephrectomies, and/or removal of polycystic or diseased kidneys) within the past 5 years?		

   f) Complete **TABLE** 4E in this document summarizing this individual's training and experience. Include the number of laparoscopic nephrectomies (and open nephrectomies if applicable) in which the individual participated as the primary surgeon or first assistant.

g) Donor Recovery 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 past 5 years. A blank log for documenting open and laparoscopic living donor nephrectomies has been provided as **TABLE** 4Fin 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 or associated recovery hospital. 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.

Part3D, Section 3 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:

If this application is being submitted for a change in personnel then you only need to complete this section for individuals whose credentials were not submitted in a previous application from this hospital.

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 employment at this hospital (MM/DD/YY): ______________

   c) Percentage of professional time spent supporting living kidney transplantation: _______% = _____ 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 4E** (at the end of this document) summarizing this individual's training and experience. Include the number of open and laparoscopic nephrectomies 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 3D, Section 4 - 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? The 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 who is independent of the decision to transplant the potential recipient.

Part 3D, Section 5 - Protocols

1. Kidney transplant programs that perform living donor kidney recoveries must demonstrate that they have written protocolsas listed below. <u>Submission of protocols is not required as a part of this application.</u>

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 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 • 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: • 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. • Documentation of disclosure to donor candidate by the hospital that it is unlawful to sell or purchase human organs.		

Written protocols must address at a minimum the areas listed below:	**Included in Protocol?**	
	Yes	**No**

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

Table 1: Certificate of Investigation

List all transplant surgeons and physicians currently involved in the program.

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 Proposed Primary Surgeon: Date:

Print name:

Signature of Proposed 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

KIDNEY TRANSPLANT PROGRAM

Member Code:	Name of Transplant 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 deceased donor kidney transplantation, living donor kidney transplantation, or both as applicable. Add additional rows 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 **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	**Address**	**Phone**	**Fax**	**Email**

Identify living donor recovery surgeons:

Name	**Open**	**Lap**	**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.

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)** 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 application includes living donor 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 of Anesthesiology** who will be involved with this program:

Name	L	D	Address	Phone	Fax	Email

Table 4– Sample Logs

TABLE 4A – Primary Surgeon - Transplant Log (Sample)
Complete separate form for each transplant hospital

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 in date order

#	**Date of Transplant**	Medical Record/ OPTN ID #	**Primary Surgeon**	**1st Assistant**
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
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21				
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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				
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28				
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31				
32				
33				
34				
35				

Extend lines on log as needed

Director's Signature: ____ Date: ____________________

TABLE 4C – 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 transplant hospital where transplants were performed:	
Date range of physician's appointment/training: MM/DD/YY to MM/DD/YY	

Complete 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						
17						
18						
19						
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21						
22						
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25						
26						
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29						
30						
31						
32						
33						
34						
35						

Extend lines on log as needed

Director's Signature: ______________________________ **Date:** ______________

TABLE 4D – 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)	Kidney or Multi-organ?
1				
2				
3				
4				
5				

TABLE 4E – Primary Donor Surgeon(s) - Open and Laparoscopic Nephrectomies ***(Duplicate as needed)***

SUMMARY OF EXPERIENCE AND TRAINING FOR DR. ______________________________

List each transplant hospital on a separate row.

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

1) performed at least 10 open nephrectomies (living donor nephrectomies, deceased donor nephrectomies, and/or removal of polycystic or diseased kidneys) as primary surgeon or first assistant within the past 5 years; and/or
2) performed at least 15 laparoscopic nephrectomies as primary surgeon or first assistant within the past 5 years.

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

Date From To mm/dd/yy	Transplant Hospital	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 4F - Primary Donor Surgeon – Donor Recovery 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 (living donor nephrectomies, deceased donor nephrectomies, and/or removal of polycystic or diseased kidneys) as primary surgeon or first assistant within the past 5 years; ***and/or***
2) performed at least 15 laparoscopic nephrectomies as primary surgeon or first assistant within the past 5 years.

Applicable CPT codes are listed on the next page.

#	Date of Nephrectomy	Donor ID #	Nephrectomy Site (Hospital)	Procedure (Check Type)		Role in Procedure (Check Type)		CPT Code
				Open	Lap.	Primary	1st Assistant	
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.

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