Part 3: Lung Transplant Program

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

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

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

Name	Date of Appointment	Primary areas of responsibility

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

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

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

a) Name: _____

b)
Date of 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.

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

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

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

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

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

f) Transplant l Training: List the name of the transplant hospital(s) at which lung and/or heart/lung transplant training (residency/fellowship) was received including program director(s) names, applicable dates, and the number of transplants and procurements performed. If the surgeon is qualifying as the primary surgeon through residency or fellowship training also submit the supporting documents listed below. Refer to the Bylaws for the necessary qualifications and detailed 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**	**# of Transplants as Primary Surgeon**		**# of Transplants as First Assistant**		**# of Procurements as Primary Surgeon or First Assistant**	
			LU	**HL**	**LU**	**HL**	**LU**	**HL**
Residency:								
Fellowship:								

g) Transplant Experience (Post fellowship):

List the name of the transplant hospital(s), applicable dates, and number of lung and/or heart/lung transplants and procurements 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 (Tables 4A and 4B) of the transplant and procurement procedures. Each 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**	**# of Transplants as Primary Surgeon**		**# of Transplants as First Assistant**		**# of Procurements as Primary Surgeon or First Assistant**	
			LU	**HL**	**LU**	**HL**	**LU**	**HL**

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

Membership Criteria	Yes
1. On site	
2. Certified by the American Board of Thoracic Surgery or the foreign equivalent	
3. Thoracic Surgery Boards pending	
4. Cardiothoracic Surgery Residency	
a. Primary surgeon or 1st assistant on 15 or more lung and/or heart/lung transplants	
b. Primary surgeon or 1st assistant on 10 or more lung procurements	
c. Involved in all levels of pre-, peri-, and post-operative patient care within the last 2 years	
d. Training program approved by American Board of Thoracic Surgery	
5. 12-Month Transplant Fellowship	
a. Primary surgeon or 1st assistant on 15 or more lung and/or heart/lung transplants	
b. Primary surgeon or 1st assistant on 10 or more lung procurements	
c. Involved in all levels of pre-, peri-, and post-operative patient care within the last 2 years	
d. Training program approved by American Board of Thoracic Surgery	
6. Experience (Post Fellowship)	
a. Primary surgeon or 1st assistant on 15 or more lung transplants over a minimum of 2 years and a maximum of 5 years. Of these 15, at least 10 were performed as primary surgeon	
b. Primary surgeon or 1st assistant on 10 or more lung procurements	
c. Involved in all levels of pre-, peri-, and post-operative patient care within the last 2 years	
7. Pediatric Pathway	
a. Program serves predominantly pediatric patients	
b. Individual has maintained current working knowledge in all aspects of lung 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	

i) Describe in detail the proposed primary surgeon's level of involvement in this transplant program, and if applicable, describe the surgeon's plan for coverage of transplant programs located in multiple transplant hospitals. (Expand rows below as necessary and use complete sentences (i.e. narrative descriptions) for each).

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

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

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

PART 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 on 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/Other Surgeons (Duplicate this section as needed). Provide the attachments listed below:

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

a) Name: _____

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

b) Date of 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.

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

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

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

e) Transplant Training (Residency/Fellowship): List the name of the transplant hospital(s) at which lung and/or heart/lung transplant training (residency/fellowship) was received, Iinclude the 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	# of Transplants as Primary Surgeon		# of Transplants as First Assistant		# of Procurements as Primary Surgeon or First Assistant	
			LU	HL	LU	HL	LU	HL
Residency:								
Fellowship:								

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

Date From – To MM/DD/YY	Transplant Hospital	Program Director	# of Transplants as Primary Surgeon		# of Transplants as First Assistant		# of Procurements as Primary Surgeon or First Assistant	
			LU	HL	LU	HL	LU	HL

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

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

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

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

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

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

a) Name:_____

b)

Date of 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.

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) at which lung and/or heart/lung 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 whom 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.
- A recipient log(s) (Table 4C) that includes the date of transplant and the patient's medical record and/or OPTN ID number. Each 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	# Lung Patients Followed			# Heart/Lung Patients Followed		
			Pre	Peri	Post	Pre	Peri	Post

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

- Two supporting letters - at least one must be from the lung transplant surgeon with whom the pulmonologist has previously worked.
- A recipient log(s) (Table 4C) that includes the date of transplant and the patient's medical record and/or OPTN ID number. Each 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	# Lung Patients Followed			# Heart/Lung Patients Followed		
			Pre	Peri	Post	Pre	Peri	Post

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

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

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

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

Membership Criteria	Yes
1. On site	
2. M.D., D.O. or equivalent degree	
3. Certified in pulmonary medicine by the American Board of Internal Medicine, Pediatrics or the foreign equivalent	
4. Achieved eligibility in Pulmonary Medicine	
5. Direct involvement in lung transplant patient care within the last 2 years	
6. Pulmonary Medicine fellowship	
a. Participated in the primary care of 15 or more lung and/or heart/lung transplant recipients for a minimum of 3 months from the time of their transplant	
b. Involved with all aspects of lung transplant patient care	
c. Observed 3 or more lung or heart/lung procurements and transplants	
d. Observed the evaluation of the donor and donor process, and management of at least 3 multiple organ donors which include the lung and/or heart/lung	
7. 12-Month Transplant Pulmonology Fellowship	
a. Participated in the primary care of 15 or more lung and/or heart/lung transplant recipients for a minimum of 3 months from the time of their transplant	
b. Involved with all aspects of lung transplant patient care	
c. Observed 3 or more lung or heart/lung procurements and transplants	
d. Observed the evaluation of the donor and donor process and management of at least 3 multiple organ donors that include the lung and/or heart/lung	
8. Experience in lung transplantation (post-fellowship)	
a. 2-5 years experience on an active lung transplant service	
b. Participated in the primary care of 15 or more lung and/or heart/lung transplant recipients for a minimum of 3 months from the time of their transplant	
c. Observed 3 or more lung or heart/lung procurements and transplants	
d. Observed the evaluation of the donor and donor process and management of at least 3 multiple organ donors that include the lung or heart/lung	
9. Pediatric Pathway	
a. Program serves predominantly pediatric patients	
b. Individual has maintained current working knowledge in all aspects of lung transplantation and patient care within the last 2 years.	

Membership Criteria	Yes
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	
10. 12-Month Conditional Pathway - ***Only available to existing programs***	
a. Board Certified Pulmonologist	
b. Participated in the primary care of 8 or more lung and/or heart/lung transplant recipients for a minimum of 3 months from the time of their transplant. At least one-half of these patients must be single and/or double lung transplant recipients	
c. If qualifying by virtue of acquired clinical experience, this experience must be equal to 12 months on an active lung transplant service acquired over a maximum of 2 years.	
d. A consulting relationship with counterparts at another member transplant hospital approved for lung transplantation has been established (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 hospitals. (Expand rows as necessary and use complete sentences (i.e. narrative descriptions) for each).

	Describe Involvement
Candidate Evaluation Process	
Care of Acute and Chronic Lung Failure	
Cardiopulmonary Bypass	
Donor Selection	
Recipient Selection	
Pre- and Postoperative Ventilator Care	
Postoperative Immunosuppressive Therapy	

Histologic Interpretation and Grading of Lung Biopsies for Rejection	
Long-term Outpatient Follow-up	
Coverage of Multiple Transplant Hospitals (if applicable)	
Additional Information	

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

	Describe Training/Experience
Candidate Evaluation Process	
Care of Acute and Chronic Lung Failure	
Cardiopulmonary Bypass	
Donor Selection	
Recipient Selection	
Pre- and Postoperative Ventilator Care	
Postoperative Immunosuppressive Therapy	

Histologic Interpretation and Grading of Lung Biopsies for Rejection	
Long-term Outpatient Follow-up	
Additional Information	

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

Complete this section of the application to describe the involvement, training, and experience of additional/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 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
	3C 2a	Current C.V.
	3C 2b	A letter from the Credentialing Committee of the applicant hospital stating that the physician meets all requirements to be in good standing. Please provide an explanation of any status other than active/full.
	3C 2c,e,f	A letter from the Physician detailing his/her commitment to the program and level of involvement in substantive patient care.

a) Name: _____

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

b) _

Date of 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.

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

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

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

e) Training (Fellowship): List the program(s) at which lung and/or heart/lung transplant training was received including 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	# Lung Patients Followed			# Heart/Lung Patients Followed		
			Pre	Peri	Post	Pre	Peri	Post

f) Transplant Experience (Post fellowship only): List the name of the transplant hospital(s), applicable dates, and the number of lung and/or heart-lung patients 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	# Lung Patients Followed			# Heart/Lung Patients Followed		
			Pre	Peri	Post	Pre	Peri	Post

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

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

h) Describe the physician's transplant training and experience in the role of transplant patient management in the areas listed below. (Expand rows as necessary and use complete sentences (i.e. narrative descriptions) for each).

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

Table 1: Certificate of Investigation

List all transplant surgeons and physicians currently involved in this 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 Primary Surgeon: Date:

Print name:

Signature of Primary Physician: Date:

Print name:

* Expand rows as needed

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 to UNOS a written Program Coverage Plan, which documents how 100% medical and surgical coverage is provided by individuals credentialed by the transplant 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

LUNG 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. 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	Address	Phone	Fax	Email

The **surgeons** who perform transplants are:

Name	Additional	Other	Address	Phone	Fax	Email

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

Name	Additional	Other	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	Address	Phone	Fax	Email

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

Name	Address	Phone	Fax	Email

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

Name	Address	Phone	Fax	Email

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

Name	Address	Phone	Fax	Email

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

Name	Address	Phone	Fax	Email

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

Name	Address	Phone	Fax	Email

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

Name	Address	Phone	Fax	Email

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

Organ:	
Name of Proposed Primary Surgeon:	
Name of transplant 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				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				

Extend lines on log as needed
Patient ID should <u>not</u> be name or Social Security Number.

Director's Signature: _____ Date: _____

Table 4B - Primary Surgeon - Procurement Log (Sample)
Complete separate form for each transplant hospital

Organ:	
Name of Proposed Primary Surgeon:	
Name of transplant 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	Medical Record/ OPTN ID # of Donor	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				
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34				
35				

Extend lines on log as needed

Director's Signature: _____ Date: _____

Table 4C - Primary Physician – Recipient Log (Sample)

Complete separate form for each transplant hospital

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	

List cases in date order

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

#	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						
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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 (Transplant Hospital)
1			
2			
3			
4			
5			

Donor Selection and Management

#	Date of Procurement	Medical Record/ OPTN ID #	Location of Donor (Hospital)	Lung, Heart/Lung, or Multi-organ
1				
2				
3				
4				
5				