

APPLICATION FOR APPROVAL FOR INSTITUTIONAL MEMBERSHIP

**AS A HOSPITAL BASED TISSUE TYPING LABORATORY
IN AN EXISTING MEMBER TRANSPLANT HOSPITAL**

IN THE ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK (OPTN)

UNOS
700 North 4th Street
Richmond, VA 23219
Main Phone: 804-782-4800

Name of Member Hospital: _____

Name Laboratory: _____

Address: _____

City, State, & Zip Code: _____

Contact Person and Title: _____

Phone Number: (_____) _____

PUBLIC BURDEN STATEMENT: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0184. Public reporting burden for the applicant for this collection of information is estimated to average 40 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 10-33, Rockville, Maryland 20857.

CERTIFICATION

The undersigned, a duly authorized representative of the applicant, does hereby certify that the answers and attachments to this application are true, correct and complete, to the best of his or her knowledge after investigation. By submitting this application to the OPTN, the applicant acknowledges that its duly authorized representatives have received and read the current Charter, Bylaws, and Policies of OPTN and the applicant agrees: (i) to be bound by the terms thereof, including amendments thereto, if the applicant is granted membership and (ii) to be bound by the terms, thereof, including amendments thereto, in all matters relating to consideration of the application without regard to whether or not the applicant is granted membership.

Date: _____

Signature: _____

Print Name: _____

Applicant # _____

Print Title: _____

Histocompatibility Laboratory

1. A histocompatibility laboratory **must** complete this application for institutional membership. The Criteria for Institutional Membership are found in the Bylaws, which can be accessed on the OPTN website at <http://optn.transplant.hrsa.gov/>.
2. By submitting this application to the OPTN, the applicant acknowledges that its duly authorized representatives have received and read the current Charter and Bylaws of the OPTN and the applicant agrees: (i) to be bound by the terms thereof, including amendments thereto, if the applicant is granted membership and (ii) to be bound by the terms thereof, including amendments thereto, in all matters relating to consideration of the application without regard to whether or not the applicant is granted membership.
3. A duly authorized representative of the applicant must review the answers and attachments to the Application, perform sufficient investigation to determine accuracy and completeness, and sign and date the Certification on the cover page of the Application. Failure to furnish accurate and complete information in connection with the Application and subsequent site visits and requests for supplemental information constitutes grounds for denial or suspension of OPTN membership.
4. Additional Instructions are provided under Part 6, Section C(1).
5. Attach additional pages as necessary and reference the question and page number on each attachment. Expand rows in tables as needed to completely answer the questions.
6. Answer all questions in full and do not use both sides of the page. "See C.V." is not an acceptable answer.
7. Supporting documentation such as C.V.'s, should be included as requested to document compliance with the requirements. Documentation may be blinded in such a way as to protect patient confidentiality.
8. Application responses must be typed and complete. Do not omit pages that were not used. The Membership and Professional Standards Committee (MPSC) may not accept for review applications that are not appropriately completed and that are missing the supporting documents for the proposed primary individual(s). Applications determined to be incomplete may be returned to the institution.
- 9.
9. **Submission of the Application**

When the application is complete and ready for submission, record the date it is being sent on the Processing Record Form.

Return the original application and one (1) complete copy. Also return a copy of the application that has been scanned to a CD in PDF format. Label the CD with the laboratory name, contact name, and date, and include a table of contents.

Express Mail:

UNOS
Membership Services
700 North 4th Street
Richmond, VA 23219

US Mail:

UNOS
Membership Services
PO Box 2484
Richmond, VA 23218

Main Phone: (804) 782-4800

Processing of the application will not begin if the ASHI or CAP Executive Office has not received payment of the laboratory's accreditation fees.

Retain these instructions, an entire copy of your submission and the Inspector's Checklist to help you prepare for the inspection.

The Accreditation Manager will perform an initial review of the application.