

Expiration Date:  
\_\_\_\_\_

## PERSONNEL CHANGE APPLICATION

### CLINICAL TRANSPLANT PROGRAM

## ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK (OPTN)

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

**Name of Hospital:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
\_\_\_\_\_

**City, State, & Zip Code:** \_\_\_\_\_

**Application 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 10 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 agrees: (i) to be bound by the Organ Procurement and Transplantation Network's rules and regulations, 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:** \_\_\_\_\_

**Member Code:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Title:** \_\_\_\_\_

## INSTRUCTIONS FOR THE COMPLETION OF PERSONNEL CHANGE APPLICATION

1. A duly authorized representative of the transplant hospital must review the answers and attachments to the change forms, perform sufficient investigation to determine accuracy and completeness, and sign and date the Certification on the cover page of the form. Failure to furnish accurate and complete information in connection with the form and subsequent site visits and requests for supplemental information, constitutes grounds for denial or suspension of OPTN membership. (Authorized representatives include hospital CEO/President, OPTN Representative, and Program Directors. **Individuals whose credentials are being submitted should not sign the application.**)
2. Application responses must be typed and complete. Do not omit pages that were not used.
3. Do not submit two-sided pages.
4. Attach additional pages as necessary and reference the question and page number on each attachment. **Expand table rows as needed to fully answer questions.**
5. **Answer all questions that pertain to the primary surgeon and/or primary physician change in full. "See C.V." and "see logs" are not acceptable answers.** You only need to complete the pages that are applicable to the change(s) that have taken place except for Part 3A and Tables 1-3, which should be answered for all applicants.  
(Part 4A and Tables 1-3 must be completed for all pancreas islet applicants).
6. CVs should be included for all primary and new personnel listed. Abbreviated CVs that do not include publications and presentations are preferred.
7. Each application should be loose bound with tabs and organized in the following sequence:
  - a) Signed Cover/Certification Page
  - b) Application form
  - c) Signed Program Coverage Plan
  - d) Documentation of Medicare/Medicaid certification of this program (as applicable)
  - e) Letters from Hospital Credentialing Committee
  - f) Letters of Commitment
  - g) Letters of Reference
  - h) Logs of transplant and procurement procedures (and living donor hepatectomies/nephrectomies as applicable) for the primary surgeon(s) and patient logs for the primary physician.  
Title each log with surgeon/physician name, date range, and hospital where the experience occurred.  
Please use a separate log for each institution.
  - i) CVs (
  - j) Cumulative Recipient log (Islet only)
  - k) Allocation Report (Islet only)
8. Supporting documentation such as letters of support, letters of commitment, and patient logs must be included as requested to document compliance with OPTN requirements. Documentation may be blinded in such a way as to protect patient confidentiality. Checklists are provided throughout the application to help applicants compile the documentation that is required. Each item in the checklist is cross referenced to the application questions.
9. 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.
10. The Criteria for Institutional Membership are found in the Bylaws which can be accessed on the OPTN website at <http://optn.transplant.hrsa.gov/>.

11. **Return the original and one (1) complete paper copy of all application materials.**

12. Completed packets should be shipped as listed below:

Express Mail:

UNOS

Membership Services

700 North 4<sup>th</sup> Street

Richmond, VA 23219

US Mail:

UNOS

Membership Services

PO Box 2484

Richmond, VA 23218

Main Phone: (804) 782-4800