Part 3: Liver Transplant Program
Including Programs Performing Living Donor Recoveries

If the application is also being used for the living donor component, complete all applicable sections for key personnel and also include Part 4 if applying for initial approval to perform living donor recoveries. All living donor component applications complete Part 4: Section 2.

This application is for (check all that applies):

	Liver Transplantation	Living Donor Recoveries/ Component
New Program		
Key Personnel Change		
Reactivation		

Table 1: OPTN Staffing Report

Member Code:	**Name of Hospital:**	
Main Program Phone Number:	**Main Program Fax Number:**	**Hospital URL:** http://www
Toll Free Phone Number for Patients:		**Hospital #:**

Refer to the staffing audit sent with this application and complete the table below for staff that are not captured on the staffing audit or to update information for current staff, including deleting (DEL) an individual. If you did not receive an audit with this application, complete the entire staffing report. **Check "L" and/or "D" to specify each individual's involvement with deceased donor liver transplantation, living donor liver recoveries, or both, as applicable.** Add additional rows as necessary.

Identify the **transplant program medical and surgical director(s)**.

DEL	Name	L	D	Address	Phone	Fax	Email

Identify the **primary and additional surgeons** who perform transplants for the program and living donor recoveries.

DEL	Name	L	D	Address	Phone	Fax	Email

Identify **other surgeons** who perform transplants for the program and living donor recoveries.

DEL	Name	L	D	Address	Phone	Fax	Email

Identify **the primary and additional physicians** (internists) who participate in this transplant program.

DEL	Name	L	D	Address	Phone	Fax	Email

Identify **other physicians** (internists) who participate in this transplant program.

DEL	Name	L	D	Address	Phone	Fax	Email

Identify the **transplant program administrator(s)/hospital administrative director(s)/manager(s)** who will be involved with this program. The * denotes the primary transplant administrator.

DEL	Name	L	D	Address	Phone	Fax	Email
	*						

Identify the **clinical transplant coordinator(s)** who will be involved with this program.

DEL	Name	L	D	Address	Phone	Fax	Email

Identify the **data coordinator(s)** who will be involved in this transplant program. The * denotes the primary data coordinator.

DEL	Name	L	D	Address	Phone	Fax	Email
	*						

Identify the **social worker(s)** who will be involved with this program.

DEL	Name	L	D	Address	Phone	Fax	Email

Identify the **Independent Donor Advocate(s) (IDA)** who will be involved in the care of living donors (complete only if the application includes changes to the living donor component).

DEL	Name	Address	Phone	Fax	Email

Identify the **pharmacist(s)** who will be involved with this program.

DEL	Name	L	D	Address	Phone	Fax	Email

Identify the **financial counselor(s)** who will be involved with this program.

DEL	Name	L	D	Address	Phone	Fax	Email

Identify the **director of anesthesiology** who will be involved with this program.

DEL	Name	L	D	Address	Phone	Fax	Email

Identify the anesthesiologist(s) who will be involved with this program.

DEL	Name	L	D	Address	Phone	Fax	Email

Identify the **QAPI team member(s)** who will be involved with this program.

DEL	Name	L	D	Address	Phone	Fax	Email

Identify **any other transplant staff** who will be involved with this program**.**

DEL	Name	Title	L	D	Address	Phone	Fax	Email

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

Identify the surgical and/or medical director(s) of the liver transplant program and/or the living donor component and submit a C.V. for each program director. Briefly describe the leadership responsibilities for each individual, including their role in living donor liver recoveries, if applicable.

Name	Date of Appointment	Primary Areas of Responsibility

Part 3B, Sections 1 & 2: Personnel – Surgical – Primary Surgeon(s)

1. **Identify the primary liver transplant surgeon and/or living donor surgeon #1.**

Name:

a) Provide the following dates (use MM/DD/YY):

Date of employment at this hospital:
Primary Living Donor Recovery Surgeon #1

b) This surgeon is being proposed as (check all that apply):

Primary Liver Transplant Surgeon and/or	
Primary Living Donor Recovery Surgeon #1	

If the proposed individual is already designated as the approved OPTN primary liver surgeon and the application is for a personnel change as one of the primary living donor surgeons only, complete c) through g) only.

c) Does the surgeon have FULL privileges at this hospital?

Yes	
No	

If the surgeon does **not** currently have full privileges:

Date full privileges to be granted (MM/DD/YY):
Explain the individual's current credentialing status, including any limitations on practice:

d) How much of the surgeon's professional time is spent on site at this hospital?

Percentage of professional time on site:
Number of hours per week:

e) How much of the surgeon's professional time is spent on site at other facilities (hospitals, health care facilities, and medical group practices)?

Facility Name	Type	Location (City, State)	% Professional Time On Site

f) List the surgeon's current board certification(s) below. If board certification is pending, indicate the date the exam has been scheduled. If the surgeon has been recertified, use that date. Provide a copy of certification(s).

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

g) Check the applicable pathway through which the surgeon will be proposed.
Refer to the bylaws for the necessary qualifications and more specific descriptions of the required supporting documents.

Membership Criteria	
Two Year Transplant Fellowship	
Clinical Experience (Post Fellowship)	
Pediatric Pathway	
Living Donor Liver Experience – Criteria for Full Approval	
Living Donor Liver Experience – Criteria for Conditional Approval	

h) Transplant Experience (Post Fellowship)/Training (Fellowship):
List the name(s) of the transplant hospital(s), applicable dates, program director name(s), and the number of transplants and procurements performed by the surgeon at each transplant hospital.

Training and Experience	**ASTS Approved Programs ? Y/N**	**Date** (MM/DD/YY)		**Transplant Hospital**	**Program Director**	**# LI Transplants as Primary**	**# LI Transplants as 1st Assistant**	**# of LI Procurements as Primary or 1st Assistant**
		Start	**End**					
Fellowship Training								
Experience Post - Fellowship								

i) Describe in detail the proposed primary surgeon's level of involvement in **this** transplant program as well as **prior** training and experience.

	Describe Level of Involvement in This Transplant Program	**Describe Prior Training/Experience**
Pre-Operative Patient Management (Patients With End Stage Liver Disease)		
Recipient Selection		
Donor Selection		
Histocompatibility and Tissue Typing		
Transplant Surgery		
Post-Operative Care and Continuing Inpatient Care		
Use of Immunosuppressive Therapy		
Differential Diagnosis of Liver Dysfunction in the Allograft Recipient		
Histologic Interpretation of Allograft Biopsies		
Interpretation of Ancillary Tests for Liver Dysfunction		
Long Term Outpatient Care		

Living Donor Transplantation (if applicable)		
Pediatric (if applicable)		
Coverage of Multiple Transplant Hospitals (if applicable)		
Additional Information:		

2. **Primary Living Donor Recovery Surgeon #2.** Complete this section ONLY if applying for initial approval to perform living donor recoveries or if making a change in key personnel for both of the primary living donor surgeons (one of the surgeons, use Section 1; both of the surgeons, use Sections 1 and 2).

Name:

a) Provide the following dates (use MM/DD/YY):

Date of employment at this hospital:
Date assumed role of primary surgeon:

b) Does the surgeon have FULL privileges at this hospital? (check one)

Yes	
No	

If the surgeon does **not** currently have full privileges:

Date full privileges to be granted (MM/DD/YY):
Explain the individual's current credentialing status, including any limitations on practice:

c) How much of the surgeon's professional time is spent on site at this hospital?

Percentage of professional time on site:
Number of hours per week:

d) How much of the surgeon's professional time is spent on site at other facilities (hospitals, health care facilities, and medical group practices)?

Facility Name	**Type**	**Location (City, State)**	**% Professional Time On Site**

e) List the surgeon's current board certification(s) below. If board certification is pending, indicate the date the exam has been scheduled. If the surgeon has been recertified, use that date. Provide a copy of certification(s).

Board Certification Type	**Certification Effective Date/ Recertification Date** (MM/DD/YY)	**Certification Valid Through Date** (MM/DD/YY)	**Certificate Number**

f) Summarize how the surgeon's experience fulfills the membership criteria.
Check the applicable pathway through which the surgeon will be proposed.
Refer to the bylaws for the necessary qualifications and more specific descriptions of the required supporting documents.

Membership Criteria	
Two Year Liver Transplant Fellowship	
Experience (Post Fellowship)	
Pediatric Pathway	
Living Donor Liver Experience – Criteria for Full Approval	
Living Donor Liver Experience – Criteria for Conditional Approval	

g) Transplant Experience (Post Fellowship)/Training (Fellowship):
List the name(s) of the transplant hospital(s), applicable dates, program director name(s), and the number of transplants and procurements performed by the surgeon at each transplant hospital.

Training and Experience	ASTS Approved Programs? Y/N	Date (MM/DD/YY)		Transplant Hospital	Program Director	# LI Transplants as Primary	# LI Transplants as 1st Assistant	# of LI Procurements as Primary or 1st Assistant
		Start	End					
Fellowship Training								
Experience Post Fellowship								

h) Describe in detail the proposed primary surgeon's level of involvement in **this** transplant program as well as **prior** training and experience.

	Describe Level of Involvement in This Transplant Program	**Describe Prior Training/Experience**
Pre-Operative Patient Management (Patients With End Stage Liver Disease)		
Recipient Selection		
Donor Selection		
Histocompatibility and Tissue Typing		
Transplant Surgery		
Post-Operative Care and Continuing Inpatient Care		
Use of Immunosuppressive Therapy		
Differential Diagnosis of Liver Dysfunction in the Allograft Recipient		
Histologic Interpretation of Allograft Biopsies		
Interpretation of Ancillary Tests for Liver Dysfunction		
Long Term Outpatient Care		
Living Donor Transplantation (if applicable)		

Pediatric (if applicable)		
Coverage of Multiple Transplant Hospitals (if applicable)		
Additional Information:		

Table 2: Primary Surgeon - Transplant Log (Sample)

Complete a 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. Extend lines on log as needed. Patient ID should not be name or Social Security Number.

#	Date of Transplant	Medical Record/ OPTN Patient 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				

Director's Signature	**Date**
Print Name	

Table 3: 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. Patient ID should not be name or Social Security Number. Insert additional rows as needed.#

	Date of Procurement	**Donor ID Number**	**Location of Donor (hospital)**	**Comments (LD/CAD/Multi-organ)**
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				

Director's Signature	**Date**
Print Name	

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

Organ:	
Name of proposed primary living donor surgeon:	
Date range of surgeon's appointment/training: MM/DD/YY to MM/DD/YY	

This log will provide documentation that demonstrates that this individual has experience as the primary surgeon or first assistant in major hepatic resection surgeries, including living donor hepatectomies.

Documentation should include the date of the surgery, medical records identification and/or OPTN/UNOS identification number, the role of the surgeon in the operative procedure, and the Current Procedural Terminology (CPT) code for the procedure. When documenting involvement in living donor hepatectomies, be sure to specify that the procedure was performed on the donor if the corresponding CPT code is not provided. It is recognized that in the case of pediatric living donor transplantation, the living organ donation may occur at a hospital that is distinct from the approved transplant hospital.

List cases in date order. Patient ID should not be name or Social Security Number. Insert additional rows as needed.

#	Date of Surgery	Medical Records/ UNOS ID #	Surgeon Role: Primary/ 1st Assistant	Recovery Hospital	CPT Code
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					

17					
18					
19					
20					

Part 3B: Section 3- Personnel, Additional Surgeon(s)

Complete this section of the application to describe surgeons involved in the program that are not designated as primary. For each surgeon, they should be designated as additional as described below. Duplicate this section as needed.

Additional transplant surgeons must be credentialed by the transplant hospital to provide transplant services and be able to independently manage the care of transplant patients, including performing the transplant operations and organ procurement procedures.

1. Identify the additional transplant surgeon:

Name:

a) Provide the following dates (use MM/DD/YY):

Date of employment at this hospital:

b) This surgeon is involved as a (check all that apply):

Liver Transplant Surgeon and/or	
Living Donor Liver Recovery Surgeon	

c) Does the surgeon have FULL privileges at this hospital? (check one)

Yes	
No	

If the surgeon does **not** currently have full privileges:

Date full privileges to be granted (MM/DD/YY):
Explain the individual's current credentialing status, including any limitations on practice:

d) How much of the surgeon's professional time is spent on site at this hospital?

Percentage of professional time on site:
Number of hours per week:

e) How much of the surgeon's professional time is spent on site at other facilities (hospitals, health care facilities, and medical group practices)?

Facility Name	Type	Location (City, State)	% Professional Time On Site

f) List the surgeon's current board certification(s) below. If board certification is pending, indicate the date the exam has been scheduled. If the surgeon has been recertified, use that date. Provide a copy of the certifications(s).

Board Certification Type	**Certification Effective Date/ Recertification Date** (MM/DD/YY)	**Certification Valid Through Date** (MM/DD/YY)	**Certificate Number**

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

1. Identify the primary transplant physician:

Name:

a) Provide the following dates (use MM/DD/YY):

Date of employment at this hospital:
Date assumed role of primary physician:

b) Does the physician have FULL privileges at this hospital? (check one)

Yes	
No	

If the physician does **not** currently have full privileges:

Date full privileges to be granted (MM/DD/YY):
Explain the individual's current credentialing status, including any limitations on practice:

c) How much of the physician's professional time is spent on site at this hospital?

Percentage of professional time on site:
Number of hours per week:

d) How much of the physician's professional time is spent on site at other facilities (hospitals, health care facilities, and medical group practices)?

Facility Name	**Type**	**Location** (City, State)	**% Professional Time On Site**

e) List the physician's current board certification(s) below. If board certification is pending, indicate the date the exam has been scheduled. If the physician has been recertified, use that date. Provide a copy of the certifications(s)

Board Certification Type	**Certification Effective Date/ Recertification Date** (MM/DD/YY)	**Certification Valid Through Date** (MM/DD/YY)	**Certificate Number**

f) Summarize how the physician's experience fulfills the membership criteria. Check the applicable pathway through which the physician will be proposed.

Refer to the bylaws for the necessary qualifications and more specific descriptions of the required supporting documents.

Membership Criteria	
12 Month Transplant Hepatology Fellowship	
Clinical Experience (Post Fellowship)	
3 Year Pediatric Gastroenterology Fellowship	
Pediatric Transplant Hepatology Fellowship ***for Board-Certified or Eligible Pediatric Gastroenterologists***	
Combined Training/Experience ***for Board-Certified or Eligible Pediatric Gastroenterologists***	
Pediatric Pathway	
12 Month Conditional Pathway – ***Only available to Existing Programs***	

OMB No. 0915-0184
Expiration Date:

g) Transplant Experience (Post Fellowship)/Transplant Training (Fellowship):
List the name(s) of the transplant hospital(s), applicable dates, program director name(s), and the number of transplant patients for which the physician provided substantive patient care (pre-, peri- and post-operatively from the time of transplant).

Training and Experience	**Date** (MM/DD/YY)		**Transplant Hospital**	**Program Director**	**#LI Patients Followed**		
	Start	**End**			**Pre**	**Peri**	**Post**
Experience Post Fellowship							
Fellowship Training							

h) Transplant Training/Experience:
If applicable, list how the physician fulfills the criteria for participating as an observer of liver transplants, liver procurements, the evaluation of the donor and donor process, and the management of at least 3 multiple organ donors.

Date From - To MM/DD/YY	**Transplant Hospital**	**# of LI Transplants Observed**	**# of LI Procurements Observed**	**# of LI Donors/ Donor Process**	**# of Multi-Organ Donors Observed Management**

i) Describe in detail the proposed primary physician's level of involvement in **this** transplant program as well as **prior** training and experience.

	Describe Level of Involvement in This Transplant Program	**Describe Prior Training/Experience**
Pre-Operative Patient Management (Patients With End Stage Liver Disease)		
Recipient Selection		
Donor Selection		
Histocompatibility and Tissue Typing		
Immediate Post-Operative and Continuing Inpatient Care		
Use of Immunosuppressive Therapy		
Differential Diagnosis of Liver Dysfunction in the Allograft Recipient		
Histologic Interpretation of Allograft Biopsies		
Interpretation of Ancillary Tests for Liver Dysfunction		
Long Term Outpatient Care		
Living Donor Transplantation (if applicable)		
Pediatric (if applicable)		
Coverage of Multiple Transplant Hospitals		

(if applicable)		
Additional Information:		

Table 5: Primary Physician – Recipient Log (Sample)

Complete a separate form for each transplant hospital.

Organ:	
Name of proposed primary physician:	
Name of hospital where transplants were performed:	
Date range of physician's appointment/training: MM/DD/YY to MM/DD/YY	

List cases in date order. Patient ID should not be name or Social Security Number. Extend lines on log as needed.

#	Date of Transplant	Medical Record/OPTN ID #	Pre-Operative	Peri-Operative	Post-Operative	Comments
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
2						

3						
24						
25						

Director's Signature	**Date**
Print Name	

Table 6: Primary Physician – Observation Log (Sample)

Organ:	
Name of proposed primary physician:	

In the tables below, document the physician's participation as an observer in organ transplants and procurements, as well as observing the selection and management of multiple organ donors that include the organ for which application is being submitted.

List cases in date order. Patient ID should not be name or Social Security Number. Extend lines on log as needed.

Transplants Observed

#	Date of Transplant	Medical Record/ OPTN ID #	Hospital
1			
2			
3			

Procurements Observed

#	Date of Procurement	Medical Record/ OPTN ID #	Donor Hospital
1			
2			
3			

Donor Selection and Management/Multi-Organ Donation

#	Date of Procurement	Medical Record/ OPTN ID #	Donor Hospital	Liver or Multi-organ?
1				
2				
3				

Part 3C: Section 2 – Personnel, Additional Physician(s) Instructions

Complete this section of the application to describe physicians involved in the program that are not designated as primary. For each physician, they should be designated as Additional as described below. Duplicate this section as needed.

Additional transplant physicians must be credentialed by the transplant hospital to provide transplant services and be able to independently manage the care of transplant patients.

1. Identify the additional transplant physician:

Name:

a) Provide the following dates (use MM/DD/YY):

Date of employment at this hospital:

b) Does the physician have FULL privileges at this hospital? (check one)

Yes	
No	

If the physician does **not** currently have full privileges:

Date full privileges to be granted (MM/DD/YY):
Explain the individual's current credentialing status, including any limitations on practice:

c) How much of the physician's professional time is spent on site at this hospital?

Percentage of professional time on site:
Number of hours per week:

d) How much of the physician's professional time is spent on site at other facilities (hospitals, health care facilities, and medical group practices)?

Facility Name	**Type**	**Location** (City, State)	**% Professional Time On Site**

e) List the physician's current board certification(s) below. If board certification is pending, indicate the date the exam has been scheduled. If the physician has been recertified, use that date. Provide a copy of the certification(s).

Board Certification Type	**Certification Effective Date/ Recertification Date**	**Certification Valid Through Date** (MM/DD/YY)	**Certificate Number**

	(MM/DD/YY)		

Part 3D: Personnel - Director of Liver Transplant Anesthesia

Liver transplant programs must designate a director of liver transplant anesthesia who has expertise in the area of peri-operative care of liver transplant patients and can serve as an advisor to other members of the team.

Refer to the bylaws for necessary qualifications and requirements.

Designated Director: _____	**Y**	**N**
Has expertise in the area of peri-operative care of liver transplant patients and can serve as an advisor to other members of the team?		
Is a Diplomate of the American Board of Anesthesiology? (required)		
If no, foreign equivalent: _____ (required)		
Experienced in liver transplant anesthesia by one of the following ways:		
• Peri-operative care of at least 10 liver transplant recipients in combination with fellowship training in critical care medicine, cardiac anesthesiology or liver transplant fellowship **OR** • Within the last five years, experience in the peri-operative care of at least 20 liver transplant recipients in the operating room **NOTE:** *Experience acquired during postgraduate (residency) training does not count for this purpose.*		
Clinical Responsibilities		
Pre-operative assessment of transplant candidates		
Participation in candidate selection		
Intra operative management		
Post operative visits		
Participation on candidate selection committee		
Consultation preoperatively with subspecialists as needed		
Participate in M & M conferences and quality improvement initiatives		
Administrative Responsibilities		
Designated member of liver transplant team		
Responsible for establishing internal policies for anesthesiology participation in peri-operative care of liver transplant recipients		
Ensures policies developed in the context of institutional needs, liver transplant volume and quality initiatives		
Ensures policies establish a clear communication channel between the liver transplant anesthesiology service and services from other disciplines (for example, peri-operative consults, candidate selection, M & M conferences, quality improvement and intra-operative guidelines based on existing and published knowledge)		
Expectation: The Director of Liver Transplant Anesthesia should earn a minimum of 8 hours of credit in transplant related educational activities from the Council for Continuing Medical Education (ACCME®) Category I Continuing Medical Education (CME) within the most recent 3 year period.		

Director's Signature	**Date**
Print Name	

Table 6: Certificate of Investigation

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

   a) This hospital has conducted its own peer review of all surgeons and physicians listed below to ensure compliance with applicable OPTN Bylaws Insert rows as needed.

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	

Table 7: Program Coverage Plan

Provide a copy of the current Program Coverage Plan and answer the questions below. The program coverage plan must be signed by either the:

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

	Yes	**No**
Is this a single surgeon program?		
Is this a single physician program?		
If single surgeon or single physician, submit a copy of the patient notice or the protocol for providing patient notification.		
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 to address urgent patient issues?		
A transplant surgeon or transplant physician may not be on call simultaneously for 2 transplant programs more than 30 miles apart unless circumstances have been reviewed and approved by the MPSC.		
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:		