Part 3: Heart Transplant Program

This application is for (check all that apply):

New Program	
Key Personnel Change	
Reactivation	

Table 1: OPTN Staffing Report

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

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. Add additional rows as necessary.

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

DEL	Name	Address	Phone	Fax	Email

Identify the **primary surgeon and additional surgeon(s)** who perform transplants for the program.

DEL	Name	Address	Phone	Fax	Email

Identify **other surgeon(s)** who perform transplants for the program.

DEL	Name	Address	Phone	Fax	Email

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

DEL	Name	Address	Phone	Fax	Email

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

DEL	Name	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	Address	Phone	Fax	Email
	*				

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

DEL	Name	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	Address	Phone	Fax	Email
	*				

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

DEL	Name	Address	Phone	Fax	Email

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

DEL	Name	Address	Phone	Fax	Email

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

DEL	Name	Address	Phone	Fax	Email

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

DEL	Name	Address	Phone	Fax	Email
	*				

Identify the **QAPI team members** who will be involved with this program.

DEL	Name	Address	Phone	Fax	Email

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

DEL	Name	Title	Address	Phone	Fax	Email

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

1. Identify the transplant program surgical and/or medical director(s) of the heart transplant program and submit a C.V. for each program director. Briefly describe the leadership responsibilities for each individual.

Name	Date of Appointment	Primary Areas of Responsibility

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

1. Identify the primary transplant surgeon:

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?

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 individual 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**

f) Check the applicable pathway(s) 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	
Cardiothoracic Surgery Residency Pathway	
Twelve-Month Heart Transplant Fellowship Pathway	
Clinical Experience Pathway	
Alternative Pathway for Predominately Pediatric Programs	

g) Transplant Experience (Post Fellowship) and 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	**ABTS Approved Program? Y/N**	**Date** (MM/DD/YY)		**Transplant Hospital**	**Program Director**	**# of Transplants as Primary**		**# of Transplants as 1st Assistant**		**# of Procurements as Primary or 1st Assistant**	
		Start	**End**			**HR**	**HL**	**HR**	**HL**	**HR**	**HL**
Residency Training											
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		
Recipient Selection		
Donor Selection		
Transplant Surgery		
Post-Operative Hemodynamic Care		
Use of Mechanical Assist Devices		
Post-Operative Immunosuppressive Therapy		
Outpatient Follow-Up		
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 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:	

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

#	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	

Part 3B, Section 2: Personnel – Additional Surgeon(s)

Complete this section 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) 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:

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.

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

Part 3C, Section 1: Personnel – Medical – 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 physician'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. Also provide a copy of the certification(s).

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

f) Check the applicable pathway(s) 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	
Twelve-Month Transplant Cardiology Fellowship Pathway	
Clinical Experience	
Alternate Pathway for Predominately Pediatric Programs	
Conditional Approval	

g) Transplant Experience (Post Fellowship) and 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**	**# Heart Patients Followed**			**# Heart/Lung Patients Followed**		
	Start	**End**			**Pre**	**Peri**	**Post**	**Pre**	**Peri**	**Post**
Fellowship Training										
Experience Post Fellowship										

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

Date From - To (MM/DD/YY)	**Transplant Hospital**	**# of HR Procurements Observed**	**# of HR Transplants Observed**	**# of HR 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**
Candidate Evaluation Process		
Pre- and Post-Operative Hemodynamic Care		
Post-Operative Immunosuppressive Therapy		
Long-Term Outpatient Follow-Up		
Care of Acute and Chronic Heart Failure		
Use of Mechanical Assist Devices		
Donor Selection		
Recipient Selection		
Histologic Interpretation and Grading of Myocardial Biopsies for Rejection		
Coverage of Multiple Transplant Hospitals (if		

applicable)		
Additional Information		

Table 6: Primary Physician – Recipient Log (Sample)

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. 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						
23						

24						
25						
26						
27						
28						
29						
30						

Director's Signature	**Date**
Print Name	

Table 7: 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			
4			
5			

Procurements Observed

#	Date of Procurement	Medical Record/ OPTN ID #	Donor Hospital
1			
2			
3			
4			
5			

Donor Selection and Management

#	Date of Procurement	Medical Record/ OPTN ID #	Donor Hospital	Heart or Multi-Organ
1				
2				
3				
4				
5				

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

Complete this section 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 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 physician'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. Also provide a copy of the certification(s).

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

Table 8: 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/UNOS bylaws. Expand 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	

   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 9: Program Coverage Plan

1. **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)
   c. Primary Surgeon and 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 two 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:		