Department of Health and Human Services
Health Resources and Services Administration

OMB No. 0915-0184
Expiration Date: XX/XX/XXXX

APPLICATION FOR APPROVAL OF AN OTHER VCA TRANSPLANT PROGRAM IN AN EXISTING MEMBER TRANSPLANT HOSPITAL ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK (OPTN)

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

Name of Hospital:	
Address:	
City, State, & Zip Code:	
Contact Person and Title:	
Phone Number:	**Email:**

Other VCA Type (check one)

Genitourinary Organs (including but not limited to uterus, internal/external male and female genitalia, or urinary bladder)		**Lower Limb** (including but not limited to pelvic structures attached to lower limb and transplanted intact, gluteal region, vascularized bone transfers from the lower extremity, anterior lateral thigh flaps, or toe transfers)	
Glands (including but not limited to adrenal or thymus)		**Musculoskeletal Composite Graft Segment** (including but not limited to latissimus dorsi, spine axis, or any other vascularized muscle, bone, nerve or skin flap)	
Spleen			

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 this collection of information is estimated to average 8 hours per response, including the time for reviewing instructions, searching existing data sources, 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 10C-03I, 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. I understand that the intentional submission of false data to the OPTN may result in action by the Secretary of the Department of Health and Human Services, and/or civil or criminal penalties. By submitting this application to the OPTN, the applicant agrees: (i) to be bound by OPTN Obligations, 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.

Print Name:	**Signature:**

Title:	**Date:**
OPTN Member Code:	