# Part 3: Upper Limb VCA Transplant Program

## Table 1: OPTN Staffing Report

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|---|---|---|
| **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. Make sure to use individuals' full, legal names (middle name/initial also included when possible) to prevent duplicate entries within the UNOS Membership Database and UNet.

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

| DEL | Name | Address | Phone | Fax | Email |
|---|---|---|---|---|---|
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Identify the **primary surgeon and additional surgeon(s)** who perform transplants for the program.

| DEL | Name | Address | Phone | Fax | Email |
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Identify **other surgeon(s)** who perform transplants for the program.

| DEL | Name | Address | Phone | Fax | Email |
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Identify the **primary physician and additional physicians** (internists) who participate in this transplant program.

| DEL | Name | Address | Phone | Fax | Email |
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Identify **other physicians** (internists) who participate in this transplant program.

| DEL | Name | Address | Phone | Fax | Email |
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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 |
|---|---|---|---|---|---|
| | * | | | | |
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Identify the **clinical transplant coordinator(s)** who will be involved in this transplant program.

| DEL | Name | Address | Phone | Fax | Email |
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| | | | | | |
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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 |
|---|---|---|---|---|---|
| | * | | | | |
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Identify the **social worker(s)** who will be involved with this program.

| DEL | Name | Address | Phone | Fax | Email |
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Identify the **pharmacist(s)** who will be involved with this program.

| DEL | Name | Address | Phone | Fax | Email |
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Identify the **financial counselor(s)** who will be involved with this program.

| DEL | Name | Address | Phone | Fax | Email |
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Identify the **anesthesiologists** who will be involved with this program. The * denotes the director of anesthesiology.

| DEL | Name | Address | Phone | Fax | Email |
|---|---|---|---|---|---|
| | * | | | | |
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Identify the **QAPI team members** who will be involved with this program.

| DEL | Name | Address | Phone | Fax | Email |
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| | | | | | |
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Identify **any other transplant staff** who will be involved with this program**.**

| DEL | Name | Title | Address | Phone | Fax | Email |
|---|---|---|---|---|---|---|
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## Part 3A: Personnel – Upper Limb VCA Transplant Program Director(s)

1. Identify the transplant program surgical and/or medical director(s) of the upper limb VCA 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 – Upper Limb VCA Primary Transplant Surgeon

1. Identify the primary upper limb VCA transplant surgeon:

| Name: |
|---|

a) Date of employment at this hospital.

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

b) Explain the individual's current credentialing status, including any limitations on practice:

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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** |
|---|---|---|---|
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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, also provide a copy of certification(s).

| **Certification Type** | **Certificate Effective Date** (MM/DD/YY) | **Certificate Valid Through Date** (MM/DD/YY) | **Certification Number** |
|---|---|---|---|
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f) **Check which membership criteria the primary VCA transplant surgeon will use to qualify. Complete steps within the criteria box selected.**

| **Membership Criteria** | **Check One** |
|---|---|
| A. Completion of a fellowship program in hand surgery that is approved by the MPSC. Any ACGME–approved fellowship program is automatically accepted by the MPSC.<br>Fellowship Hospital: _____ Dates: _____<br>Fellowship Program Director: _____ Medical or Surgical Specialty:<br>_____ | |
| B. Completion of a fellowship program in hand surgery that meets criteria in below:<br>Fellowship Hospital: _____ Dates: _____<br>Fellowship Program Director: _____ Medical or Surgical Specialty:<br>_____ | |
| C. The surgeon must have at least 2 years of consecutive and independent practice of hand surgery. The surgeon must have completed a minimum number of upper limb procedures below as the primary surgeon (document in Tables 3 through 11):<br>20 Bone<br>20 Nerve<br>20 Tendon<br>14 Skin or Wound Problems<br>10 Contracture or Joint Stiffness<br>10 Tumor<br>10 Microsurgical Procedures Free Flaps<br>6 Non-Surgical Management<br>5 Replantation or Transplant | |

| Verify the hand surgery fellowship program meets the following: | Y/N |
|---|---|
| i. The program is at a hospital that has inpatient facilities, operative suites and diagnostic treatment facilities, outpatient facilities, and educational resources. | |
| ii. The program is at an institution that has a proven commitment to graduate medical education. | |
| iii. The program director must have current certification in the sub-specialty by the American Board of Orthopedic Surgery, the American Board of Plastic Surgery, or American Board of Surgery. | |
| iv. The program should have at least two physician faculty members with hand surgery experience and current medical licensure who are actively involved in the instruction and supervision of fellows during the time of accredited education. | |
| v. The program is at a hospital that has affiliated rehabilitation medicine services. | |
| vi. The program has the resources, including adequate clinical facilities, laboratory research facilities, and appropriately trained faculty and staff, to provide research experience. | |

## Table 2: Relevant Clinical Experience Log (Sample)

The proposed primary surgeon must have observed at least two multi-organ procurements. Document those in the first table below. **Only complete the remainder of this log if the surgeon is applying without board certification or is not providing letters of recommendation requesting an exception and a plan for continuing education in lieu of American or Canadian Boards.**

| | |
|---|---|
| **Organ:** | Upper Limb VCA |
| **Name of proposed primary surgeon:** | |

**Multi-organ Procurements Observed**

| # | Date of Procurement | Medical Record/ OPTN ID # | Role of Surgeon | Multi-organs |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |

**Pre-operative Evaluations of Upper Limb Transplant Patients**

| # | Date of Evaluation | Medical Record/ OPTN ID # | Procedure | Hospital |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |

**Upper Limb Transplants**

| # | Date of Procedure | Medical Record/ OPTN ID # | Role of Surgeon | Hospital |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |

### One Year Post-operative Follow-up of Upper Limb Recipient

| # | Date of Procedure | Medical Record/ OPTN ID # | Procedure | Hospital |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |

## Table 3: Upper Limb Surgeon – **Bone Log** (Sample)

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|---|---|
| **Organ:** | Upper Limb VCA |
| **Name of proposed primary surgeon:** | |
| **Date range of surgeon's appointment/training:** MM/DD/YY to MM/DD/YY | |

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

| # | Date of Transplant | Location | Medical Record/ OPTN ID # | As Primary Surgeon (check as applicable) | Pre-Operative | Post-Operative 90 days |
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| **Director's Signature** | **Date** |
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| **Print Name** | |
|---|---|

## Table 4: Upper Limb Surgeon – **Nerve Log** (Sample)

| **Organ:** | Upper Limb VCA |
|---|---|
| **Name of proposed primary surgeon:** | |
| **Date range of surgeon's appointment/training:** MM/DD/YY to MM/DD/YY | |

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

| # | Date of Procedure | Location | Medical Record/ OPTN ID # | As Primary Surgeon (check as applicable) | Pre-Operative | Post-Operative 90 days |
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| **Director's Signature** | **Date** |
|---|---|
| **Print Name** | |

## Table 5: Upper Limb Surgeon – **Tendon Log** (Sample)

| **Organ:** | Upper Limb VCA |
|---|---|
| **Name of proposed primary surgeon:** | |
| **Date range of surgeon's appointment/training:** MM/DD/YY to MM/DD/YY | |

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

| # | Date of Procedure | Location | Medical Record/ OPTN ID # | As Primary Surgeon (check as applicable) | Pre-Operative | Post-Operative 90 days |
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| **Director's Signature** | **Date** |
|---|---|
| **Print Name** | |

## Table 6: Upper Limb Surgeon – Skin or Wound Problems Log (Sample)

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|---|---|
| **Organ:** | Upper Limb VCA |
| **Name of proposed primary surgeon:** | |
| **Date range of surgeon's appointment/training:** MM/DD/YY to MM/DD/YY | |

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

| # | Date of Procedure | Location | Medical Record/ OPTN ID # | As Primary Surgeon (check as applicable) | Pre-Operative | Post-Operative 90 days |
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| **Director's Signature** | **Date** |
|---|---|
| **Print Name** | |

## Table 7: Upper Limb Surgeon – Contracture or Joint Stiffness Log (Sample)

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|---|---|
| **Organ:** | Upper Limb VCA |
| **Name of proposed primary surgeon:** | |
| **Date range of surgeon's appointment/training:** MM/DD/YY to MM/DD/YY | |

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

| # | Date of Procedure | Location | Medical Record/ OPTN ID # | As Primary Surgeon (check as applicable) | Pre-Operative | Post-Operative 90 days |
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| **Director's Signature** | **Date** |
|---|---|
| **Print Name** | |

## Table 8: Upper Limb Surgeon – **Tumor Log** (Sample)

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|---|---|
| **Organ:** | Upper Limb VCA |
| **Name of proposed primary surgeon:** | |
| **Date range of surgeon's appointment/training:** MM/DD/YY to MM/DD/YY | |

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

| # | Date of Procedure | Location | Medical Record/ OPTN ID # | As Primary Surgeon (check as applicable) | Pre-Operative | Post-Operative 90 days |
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| **Director's Signature** | **Date** |
|---|---|
| **Print Name** | |

## Table 9: Upper Limb Surgeon – Microsurgical Procedures Free Flaps Log (Sample)

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|---|---|
| **Organ:** | Upper Limb VCA |
| **Name of proposed primary surgeon:** | |
| **Date range of surgeon's appointment/training:** MM/DD/YY to MM/DD/YY | |

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

| # | Date of Procedure | Location | Medical Record/ OPTN ID # | As Primary Surgeon (check as applicable) | Pre-Operative | Post-Operative 90 days |
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| **Director's Signature** | **Date** |
|---|---|
| **Print Name** | |

## Table 10: Upper Limb Surgeon – Non-Surgical Management Log (Sample)

| | |
|---|---|
| **Organ:** | Upper Limb VCA |
| **Name of proposed primary surgeon:** | |
| **Date range of surgeon's appointment/training:** MM/DD/YY to MM/DD/YY | |

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

| # | Date of Procedure | Location | Medical Record/ OPTN ID # | As Primary Surgeon (check as applicable) | Pre-Operative | Post-Operative 90 days |
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| **Director's Signature** | **Date** |
|---|---|
| **Print Name** | |

## Table 11: Upper Limb Surgeon – Replantation or Transplant Log (Sample)

| | |
|---|---|
| **Organ:** | Upper Limb VCA |
| **Name of proposed primary surgeon:** | |
| **Date range of surgeon's appointment/training:** MM/DD/YY to MM/DD/YY | |

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

| # | Date of Procedure | Location | Medical Record/ OPTN ID # | As Primary Surgeon (check as applicable) | Pre-Operative | Post-Operative 90 days |
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| **Director's Signature** | **Date** |
|---|---|
| **Print Name** | |

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

**Complete this section of the application to describe surgeons involved in the program that are not designated as primary, but are credentialed by the transplant hospital to provide transplant services and independently manage the care of transplant patients, including performing the transplant operations and organ procurement procedures**. **Duplicate this section as needed.**

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 - Medical Personnel, Upper Limb VCA Primary Physician

1. Identify the primary transplant physician:

| Name: |
|---|

**Check which membership criteria the primary VCA physician will use to qualify. Next steps are within the criteria box selected.**

| Membership Criteria | Check One |
|---|---|
| (1) Currently designated as the primary transplant surgeon or primary transplant physician at an active solid organ transplant program.<br>o Which solid organ transplant program? _____<br>o Proceed to Table 16, Certificate of Investigation. | |
| (2) Meets the requirements of a primary transplant surgeon or primary transplant physician in the OPTN Bylaws.<br>o Which solid organ transplant program? _____<br>o Complete the rest of the application. | |
| (3) Meets the requirements found in Appendix J.2.<br><br>Fellowship Hospital: _____ Dates: _____<br>Fellowship Program Director: _____ Medical or Surgical Specialty: _____<br><br>o Complete 1a) – e) below. | |

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 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, also provide a copy of certification(s). If the surgeon does not have current American or Canadian board certification, provide letters of recommendation requesting this exception and provide the plan for continuing education as described in the OPTN Bylaws.

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

Answer if qualifying by the primary intestine physician requirements: If the physician is not a pediatric gastroenterologist and the program serves predominately pediatric patients, please identify a pediatric gastroenterologist who will be involved in the care of transplant recipients. Provide C.V.

| Name | Board Certification | % Professional Time on Site |
|---|---|---|
| | | |

f) Check the pathway through which the primary VCA transplant physician will be proposed. Refer to the Appendices E-I in the OPTN Bylaws for the necessary qualifications and more specific descriptions of the required supporting documents.

| Membership Criteria | Check one |
|---|---|
| Residency Pathway | |
| Transplant Fellowship Pathway | |
| Pediatric Fellowship Pathway | |
| Combined Pediatric Training and Experience Pathway | |
| Clinical Experience Pathway | |
| Full (Intestine only) | |
| Conditional (Intestine only) | |

g) Transplant Experience (Post Fellowship) and Training (Fellowship): List the name(s) of the transplant hospital(s), applicable dates, and program director name(s) from either fellowship training or experience post fellowship. If a surgeon is being proposed to serve as the primary physician, also document the number of transplants and procurements performed. If a physician, document the number of patients that were 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 | # Transplants as Primary or 1st Assist (Surgeon) | # Procured as Primary or 1st Assist (Surgeon) | # Patients Followed (Physician) | | |
|---|---|---|---|---|---|---|---|---|---|
| | Start | End | | | | | Pre | Peri | Post |
| **Fellowship Training** | | | | | | | | | |
| **Experience Post Fellowship** | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

h) Training/Experience: List how the physician fulfills the criteria for participating as an observer of procurements and transplants. For procurements, the physician must have observed the evaluation, donation process, and management of the donors. **This table is only applicable if you are applying as a primary transplant physician.**

| **Date From - To** (MM/DD/YY) | **Transplant Hospital** | **# of Procurements Observed** | **# of Transplants Observed** |
|---|---|---|---|
| | | | |
| | | | |

i) Describe in detail the proposed primary physician's level of involvement in **this** transplant program as well as **prior** training and experience **under All Organs. Then also complete the organ specific section for which you are applying through (heart, lung, kidney, liver, pancreas, or intestine).**

| **Describe Level of Involvement in This Transplant Program** | | **Describe Prior Training/Experience** |
|---|---|---|
| **All Organs** | | |
| Donor Selection | | |
| Recipient Selection | | |
| Transplant Surgery (surgeon only) | | |
| Pre-operative management/care of patients with acute, chronic disease or end stage organ failure | | |
| Long term outpatient follow-up care | | |
| Immunosuppressive therapy including side effects of drugs and complications of immunosuppressive | | |
| Histological interpretation | | |

| | | |
|---|---|---|
| and grading of allograft biopsies for rejection | | |
| Fluid and electrolyte management (peds only) | | |
| Effects of transplantation and immunosuppressive agents on growth and development (peds only) | | |
| Manifestation of rejection in the pediatric patient (peds only) | | |
| **Heart, Lung** | | |
| Use of mechanical circulatory support devices/ cardiopulmonary bypass | | |
| Pre-operative hemodynamic/ ventilator care | | |
| Post-operative hemodynamic/ ventilator care | | |
| **Kidney, Liver, Pancreas, Intestine** | | |
| Differential diagnosis of organ dysfunction in the allograft recipient | | |
| Histocompatibility and tissue typing | | |
| Interpretation of ancillary tests for organ dysfunction | | |

## Table 12: Primary Physician - Transplant Log (Sample)

**Only complete this table if applying as the primary VCA transplant physician by qualifying as a primary transplant surgeon.**

| | |
|---|---|
| **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. Add rows 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 | | | | |
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| 25 | | | | |
| 26 | | | | |
| 27 | | | | |
| 28 | | | | |
| 29 | | | | |
| 30 | | | | |

| **Director's Signature** | **Date** |
|---|---|
| | |

| **Print Name** | |
|---|---|

## Table 13: Primary Physician - Procurement Log (Sample)

**Only complete this table if applying as the primary VCA transplant physician by qualifying as a primary transplant surgeon.**

| **Organ:** | |
|---|---|
| **Name of proposed primary surgeon:** | |

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

| # | Date of Procurement | Donor ID Number | Comments (LD/CAD/Multi-Organ) |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |
| 8 | | | |
| 9 | | | |
| 10 | | | |
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| 24 | | | |
| 25 | | | |
| 26 | | | |
| 27 | | | |
| 28 | | | |
| 29 | | | |
| 30 | | | |

| **Director's Signature** | **Date** |
|---|---|
| **Print Name** | |

## Table 14: Primary Physician - Recipient Log (Sample)

**Only complete this table if applying as the primary VCA transplant physician by qualifying as a primary transplant physician.**

| | |
|---|---|
| **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. Add rows as needed. Patient ID should not be name or Social Security Number.*

| # | Date of Transplant | Medical Record/ OPTN ID # | Pre-Operative | Peri-Operative | Post-Operative | Comments |
|---|---|---|---|---|---|---|
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |
| 7 | | | | | | |
| 8 | | | | | | |
| 9 | | | | | | |
| 10 | | | | | | |

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| 11 | | | | | | |
| 12 | | | | | | |
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| 30 | | | | | | |

| **Director's Signature** | **Date** |
|---|---|
| **Print Name** | |

## Table 15: Primary Physician - Observation Log (Sample)

**Only complete this table if applying as the primary VCA transplant physician by qualifying as a primary transplant physician.**

| | |
|---|---|
| **Organ:** | |
| **Name of proposed primary physician:** | |

In the tables below, document the physician's participation as an observer in transplants and procurements. For procurements, the physician must have observed the evaluation, donation process, and management of the donors.

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

Transplants Observed

| # | Date of Transplant | Medical Record/ OPTN ID # | Living Donor or Deceased | Recipient Age | Hospital |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |

Procurements Observed

| # | Date of Procurement | Medical Record/ OPTN ID # | Living Donor or Deceased |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |

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

**Complete this section of the application to describe physicians involved in the program that are not designated as primary, but are credentialed by the transplant hospital to provide transplant services and be able to independently manage the care of transplant patients. Duplicate this section as needed.**

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 16: 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** |
|---|
| |
| |
| |
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| |

   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 17: 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); or
   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. Please use the additional information section below.* | | |
| 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? | | |
| Is a transplant surgeon readily available in a timely manner to facilitate organ acceptance, procurement, and implantation? | | |
| 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 this program requesting an exemption? | | |
| If yes, provide explanation: | | |
| 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: | | |
| Additional information: | | |