Part 3: Kidney Transplant Program

Please check all applicable components for which the program is applying.

Living Donor Kidney Recoveries	
Pediatric Kidney Transplants	

Table 1: OPTN Staffing Report

Only complete this section of the application if it is for a new transplant program and/or component.

OPTN 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:**	

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[sm]. **Check all that apply to specify each individual's involvement: deceased donor kidney transplantation (D), living donor kidney recoveries (L), and/or pediatric transplantation (P)**. Add additional rows as necessary.

Identify the **program/component(s) director(s)**.

~~DEL~~	Name	L	D	P	Address	Phone	Fax	Email

Identify the **additional surgeon(s)** who will be involved.

Name	Open	Lap	D	P	Address	Phone	Fax	Email

Identify the **other surgeon(s)** who will be involved.

Name	Open	Lap	D	P	Address	Phone	Fax	Email

Identify the **additional physician(s)** who will be involved.

Name	L	D	P	Address	Phone	Fax	Email

Identify the **other physician(s)** who will be involved.

Name	L	D	P	Address	Phone	Fax	Email

Identify the **transplant program administrator(s)/hospital administrative director(s)/manager(s)** who will be involved.
Use * to denote the primary transplant administrator.

Name	L	D	P	Address	Phone	Fax	Email

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

Name	L	D	P	Address	Phone	Fax	Email

Identify the **data coordinator(s)** who will be involved.
Use * to denote the primary data coordinator.

Name	L	D	P	Address	Phone	Fax	Email

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

Name	L	D	P	Address	Phone	Fax	Email

Identify the **Independent Living Donor Advocate(s) (ILDA)** who will be involved in the care of living donors (complete if the application includes a living donor component).

Name	Address	Phone	Fax	Email

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

Name	L	D	P	Address	Phone	Fax	Email

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

Name	L	D	P	Address	Phone	Fax	Email

Identify the **anesthesiologist(s)** who will be involved.
Use a * to denote the director of anesthesiology.

Name	L	D	P	Address	Phone	Fax	Email

Identify the **QAPI team members** who will be involved**.**

Name	L	D	P	Address	Phone	Fax	Email

Identify **any other transplant staff** who will be involved **.**

Name and Title	**L**	**D**	**P**	**Address**	**Phone**	**Fax**	**Email**

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

Identify the director(s) of the kidney transplant program, the living donor component, and/or the pediatric component. Briefly describe the leadership responsibilities for each individual.
Submit a C.V. for each program director listed.

Name	Director of (Program, Living Donor Component, Pediatric Component)	Date of Appointment as Director	Leadership Responsibilities

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

Primary Kidney Transplant Surgeon	
Primary Pediatric Kidney Transplant Surgeon	

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 individual has been recertified, use that date. Provide a copy of certification(s). If the surgeon does not have current American or Canadian board certification, provide letters of recommendation requesting an exception and provide the plan for continuing education as described in the OPTN Bylaws.

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

g) Check the applicable pathway(s) through which the surgeon could qualify. Refer to the OPTN Bylaws for the necessary qualifications and more specific descriptions of the required supporting documents.

Membership Criteria	
Two-Year Transplant Fellowship	
Clinical Experience	
Primary Pediatric Transplant Surgeon Requirements – Criteria for Full Approval	
Conditional Pediatric Component Approval – Surgeon Based	

h) Transplant Training (Fellowship) and Experience (Post Fellowship):
List the name(s) of the transplant hospital(s), applicable dates, program director name(s), the total number of kidney transplants, the number of those transplants that were performed in patients under 18 years of age (if applying as primary pediatric kidney transplant surgeon), and the number of procurements performed by the surgeon at each transplant hospital.

Training and Experience	**ASTS Approved Program? Y/N**	**Date** (MM/DD/YY)		**Transplant Hospital**	**Program Director**	**Total # KI Transplants**	**# of KI Transplants in patients under 18 years (included in total)**	**Total # of KI Procurements**
		Start	**End**					
Fellowship Training								
Experience Post Fellowship								

OMB No. 0915-0184
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i) Describe in detail the proposed primary surgeon's training and experience. Each of these descriptions should be specific to each area and address pediatric training and experience if proposed as the primary pediatric surgeon.

	Describe training and/or experience in each listed area in the past 2 years
Pre-Operative Patient Management	
Recipient Selection	
Donor Selection	
Transplant Surgery	
Post-Operative Care	
Histocompatibility and Tissue Typing	
Post-Operative Immunosuppressive Therapy	
Outpatient Follow-Up	
Additional Information	

Part 3B, Section 2: Personnel – Surgical – Primary Pediatric Surgeon

Please complete the following section if the surgeon being proposed is **different** than the primary kidney transplant surgeon.

1. Identify the primary pediatric transplant surgeon:

Name:

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

Date of employment at this hospital:
Date assumed role of primary pediatric 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). 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.

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 could qualify. Refer to the OPTN Bylaws for the necessary qualifications and more specific descriptions of the required supporting documents.

Membership Criteria	
Two-Year Transplant Fellowship	
Clinical Experience	
Pediatric Transplant Surgeon Requirements – Criteria for Full Approval	
Conditional Pediatric Component Approval – Surgeon Based	

g) Transplant Training (Fellowship) and Experience (Post Fellowship):
List the name(s) of the transplant hospital(s), applicable dates, program director name(s), the total number of kidney transplants, the number of those transplants that were performed in patients under 18 years of age, and procurements performed by the surgeon at each transplant hospital.

Training and Experience	ASTS Approved Program? Y/N	Date (MM/DD/YY)		Transplant Hospital	Program Director	Total # KI Transplants	# of KI Transplants in patients under 18 years (included in total)	Total # of KI Procurements
		Start	End					
Fellowship Training								
Experience Post Fellowship								

OMB No. 0915-0184
Expiration Date: 07/31/2020

h) Describe in detail the proposed primary surgeon's training and experience. Each of these descriptions should be specific to each area and address pediatric training and experience.

	Describe training and/or experience in each listed area in the past 2 years
Pre-Operative Patient Management	
Recipient Selection	
Donor Selection	
Transplant Surgery	
Post-Operative Care	
Histocompatibility and Tissue Typing	
Post-Operative Immunosuppressive Therapy	
Outpatient Follow-Up	
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. Add rows as needed. Patient ID should not be name or Social Security Number.

Complete for all transplants. Please check whether proposed surgeon was primary/co-surgeon or 1st assistant.					**Patients under 18 years of age only**	
#	**Date of Transplant**	**Medical Record/ OPTN ID #**	**Primary Surgeon/ co-surgeon**	**1st Assistant**	**Date of Birth**	**Weight in kg at time of transplant if under 25 kg**
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						
31						
32						
33						
34						
35						
36						
37						
38						
39						
40						
41						
42						
43						
44						
45						

Director's Signature	**Date**
Print Name	

Table 3: Primary Surgeon - Procurement Log (Sample)

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.

				Role of Surgeon Please check whether proposed surgeon was primary/co-surgeon or 1st assistant.	
#	**Date of Procurement**	**Donor ID Number**	**Deceased Donor (DD) Or Living Donor (LD)**	**Primary Surgeon/ co-surgeon**	**First Assistant**
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
2					

1					
22					
23					
24					
25					
26					
27					
28					
29					
30					

Director's Signature	**Date**
Print Name	

Part 3B: Section 4 – Personnel, Additional Surgeon(s)

Complete this section of the application to describe surgeons involved in the program who 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 surgeon:

Name:

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

Date of employment at this hospital:

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

Kidney Transplant Surgeon	
Pediatric Kidney Transplant Surgeon	
Open Nephrectomy Donor Surgeon	
Laparoscopic Nephrectomy Donor Surgeon	

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.

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

Part 3B: Section 3- Living Donor Kidney Recoveries Personnel Primary Open and Laparoscopic Nephrectomy Donor Surgeon

The laparoscopic and open donor nephrectomy expertise may reside within the same or different individuals. Duplicate pages as needed.

1. Identify the primary living donor kidney recovery surgeon:

Name:

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

Primary Open Nephrectomy Donor Surgeon	
Primary Laparoscopic Nephrectomy Donor Surgeon	

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

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

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

Yes	
No	

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

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

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

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

e) Experience/Training:

	Yes	No
Did the donor surgeon complete an accredited ASTS fellowship with a certificate in kidney?		
If "Yes," complete the questions below and provide a copy of the certificate.		
Transplant hospital:		
Fellowship program director:		
Training start date: (MM/DD/YY)	Training end date: (MM/DD/YY)	

f) Describe the proposed primary donor surgeon's level of involvement in the program and if applicable, describe the donor surgeon's plan for coverage of transplant programs located in multiple transplant centers.

[Insert response here, table will expand automatically.]

g) Conversion Coverage Plan: If the open and laparoscopic expertise resides within different individuals, then the program must document how both individuals will be available to the surgical team. Describe how the center will handle surgical decisions and coverage for the laparoscopic to open conversion.

[Insert response here, table will expand automatically.]

Table 4: Primary Donor Surgeon(s) - Open and Laparoscopic Nephrectomies *(Duplicate as needed)*

Summary of Experience and Training for:	[Insert Name]

The numbers entered should be validated on the donor recovery log on the next page. Insert additional rows as needed.

Training and Experience	ASTS Approved Program? Y/N	Date (MM/DD/YY)		Transplant Hospital	Program Director	# Open Nephrectomies	# Laparoscopic Nephrectomies
		Start	End				
Fellowship Training							
Experience Post Fellowship							

Table 5: Primary Donor Surgeon – Donor Recovery Log

Application Type: (Check all that apply)	
Open Nephrectomy	
Laparoscopic Nephrectomy	

Name of proposed primary donor surgeon:	
Name of transplant center where nephrectomies were performed:	

Cases should be listed by type then date order. Insert additional rows as needed.

#	Date of Nephrectomy	Medical Record # or Donor ID	Procedure (Check Type)		Role in Procedure (Check Type)		
			Open	Lap	Primary	1st Assistant	
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							

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) The physician is being proposed as (check all that apply):

Primary Kidney Transplant Physician	
Primary Pediatric Kidney Transplant Physician	

c) 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:

d) 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:

e) 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

f) 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). If the physician 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/ Recertificatio	Certification Valid Through Date (MM/DD/YY)	Certificate Number

	n Date (MM/DD/YY)		

g) Check all applicable pathway(s) through which the proposed physician could qualify. Refer to the OPTN Bylaws for the necessary qualifications and more specific descriptions of the required supporting documents.

Membership Criteria	**Primary Kidney Transplant Physician**	**Primary Pediatric Kidney Transplant Physician**
Transplant Nephrology Fellowship		
Clinical Experience		
Three-Year Pediatric Nephrology Fellowship		
12-month Pediatric Transplant Nephrology Fellowship		
Combined Pediatric Nephrology Training and Experience		
Conditional Approval for Primary Kidney Transplant Physician-– *Only available to Existing Programs*		
Conditional Pediatric Component Approval – Physician Based		

h) 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	AST Approved Program? Y/N	Date (MM/DD/YY)		Transplant Hospital	Program Director	#KI Patients Followed		
		Start	End			Pre	Peri	Post
Fellowship Training								
Experience Post Fellowship								

i) Training/Experience. List how the physician fulfills the criteria for participating as an observer of deceased and living donor kidney transplants and kidney procurements. For procurements, the physician must have observed the evaluation, donation process, and management of the donors.

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

j) Describe in detail the proposed primary physician's raining and experience. Each of these descriptions should be specific to each area and address pediatric training and experience if proposed under one of the pediatric pathways or as the primary pediatric physician.

	Describe training and/or experience in each listed area in the past 2 years
Candidate Evaluation Process	
Pre- and Post-Operative Care	
Post-Operative Immunosuppressive Therapy	
Long-term Outpatient Follow-Up	
Care of Acute and Chronic Kidney Failure	
Donor Selection	
Recipient Selection	
Histologic Interpretation of Allograft Biopsies and Interpretation of Ancillary Tests for Renal Dysfunction	
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)	
Additional Information:	

Part 3C, Section 2: Personnel – Medical – Primary Pediatric Physician

Please complete the following section if the physician being proposed is **different** than the primary kidney transplant physician

1. Identify the primary pediatric transplant physician:

Name:

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

Date of employment at this hospital:
Date assumed role of primary pediatric 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. Provide a copy of the certification(s). If the physician 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**

f) Check all applicable pathway(s) through which the proposed physician could qualify. Refer to the OPTN Bylaws for the necessary qualifications and more specific descriptions of the required supporting documents.

Membership Criteria	
Three-Year Pediatric Nephrology Fellowship	
12-month Pediatric Transplant Nephrology Fellowship	
Combined Pediatric Nephrology Training and Experience	
Conditional Pediatric Component Approval – Physician Based	

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g) Transplant Training (Fellowship) and Transplant Experience (Post 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	**AST Approved Program? Y/N**	**Date** (MM/DD/YY)		**Transplant Hospital**	**Program Director**	**#KI Patients Followed**		
		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 deceased and living donor kidney transplants and kidney procurements. For procurements, the physician must have observed the evaluation, donation process, and management of the donors.

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

i) Describe in detail the proposed primary physician's training and experience. Each of these descriptions should be specific to each area and address pediatric training and experience.

	Describe training and/or experience in each listed area in the past 2 years
Candidate Evaluation Process	
Pre- and Post-Operative Care	
Post-Operative Immunosuppressive Therapy	
Long-term Outpatient Follow-Up	
Care of Acute and Chronic Kidney Failure	
Donor Selection	
Recipient Selection	
Histologic Interpretation of Allograft Biopsies and Interpretation of Ancillary Tests for Renal Dysfunction	
Fluid and Electrolyte Management	
Effects of Transplantation and Immunosuppressive Agents on Growth and Development	
Manifestation of Rejection in the Pediatric Patient	
Additional Information:	

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Table 6: Primary Physician – Recipient Log (Sample)

Complete a separate form for each transplant hospital.

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 Care	Peri-Operative Care	Post-Operative Care	Check if patient was under 18 years of age
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
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21						

22						
23						
24						
25						
26						
27						
28						
29						
30						

Director's Signature	**Date**
Print Name	

Table 7: Primary Physician – Evaluation Logs (Sample)

Organ:	
Name of proposed primary physician:	

In the tables below, document the physician's participation in the evaluation of potential kidney recipients as well as potential living donors.

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

Potential Recipients Evaluated

#	Date of Evaluation	Medical Record/ OPTN ID #	Hospital
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	

Only complete this log if the proposed primary transplant physician is applying through The Transplant Nephrology Fellowship, Clinical Experience, or Conditional Approval Pathways (OPTN Bylaws, Appendix E.3.A, E.3.B, or E.3.C).

Potential Living Donors Evaluated

#	Date of Evaluation	Medical Record/ OPTN ID #	Hospital
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Director's Signature	**Date**
Print Name	

Table 8: Primary Physician –Observation Log (Sample)

Organ:	
Name of proposed primary physician:	

In the tables below, document the physician's participation as an observer in kidney transplants and kidney 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 3 – 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 transplant physician:

Name:

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

Date of employment at this hospital:

b) The physician is involved as a (check all that apply):

Kidney Transplant Physician	
Pediatric Kidney Transplant Physician	

c) 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:

d) 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:

e) 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

f) 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 certifications(s).

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

Table 9: 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. 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	

   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 10: 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; or
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:		