Part 3: Liver Transplant Program

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

Living Donor Liver Recoveries	
Pediatric Liver 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 liver transplantation (D), living donor liver recoveries (L), and/or pediatric transplantation (P)**. Add additional rows as necessary.

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

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

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

Name	L	D	P	Address	Phone	Fax	Email

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

Name	L	D	P	Address	Phone	Fax	Email

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

Name	L	D	P	Address	Phone	Fax	Email

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

Name	L	D	P	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.

Name	L	D	P	Address	Phone	Fax	Email
*							

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

Name	L	D	P	Address	Phone	Fax	Email

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

Name	L	D	P	Address	Phone	Fax	Email
*							

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

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 with this program.

Name	L	D	P	Address	Phone	Fax	Email

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

Name	L	D	P	Address	Phone	Fax	Email

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

Name	L	D	P	Address	Phone	Fax	Email

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

Name	L	D	P	Address	Phone	Fax	Email

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

Name	L	D	P	Address	Phone	Fax	Email

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

Name	Title	L	D	P	Address	Phon	Fax	Email

						e		

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

Identify the director(s) of the liver 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 director listed.

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

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

1. Identify the primary liver transplant surgeon, living donor surgeon #1, and/or pediatric liver 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) This surgeon is being proposed as (check all that apply):

Primary Liver Transplant Surgeon	
Primary Living Donor Recovery Surgeon	
Primary Pediatric Liver Transplant Surgeon	

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).

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). 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	
Pediatric Transplant Surgeon Requirements – Criteria for Full Approval	
Living Donor Liver Experience – Criteria for Full Approval	
Living Donor Liver Experience – Criteria for Conditional Approval	

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

Training and Experience	**ASTS Approved Programs? Y/N**	**Date** (MM/DD/YY)		**Transplant Hospital**	**Program Director**	**Total # LI Transplants**	**# of LI Transplants in patients under 18 years (included in total)**	**# of LI Procurements**	**Total # of major hepatic resections**	**# of living donor procedures (included in total of major hepatic resections)**
		Start	**End**							
Fellowship Training										
Experience Post - Fellowship										

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 (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	
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.

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). 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.

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 OPTN Bylaws for the necessary qualifications and more specific descriptions of the required supporting documents.

Membership Criteria	
Two-Year Transplant Fellowship	
Clinical Experience	
Living Donor Liver Experience – Criteria for Full Approval	
Living Donor Liver Experience – Criteria for Conditional Approval	

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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, the total number of major hepatic resections and the number of living donor hepatectomies .

Training and Experience	ASTS Approved Programs ? Y/N	Date (MM/DD/YY)		Transplant Hospital	Program Director	# LI Transplants	# of LI Procurements	Total # of major hepatic resections	# of living donor procedures (included in total of major hepatic resections)
		Start	End						
Fellowship Training									
Experience Post Fellowship									

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

	Describe training and/or experience in each listed area in the past 2 years
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	
Additional Information	

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

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

1. Identify the primary pediatric liver 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 the surgeon 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 through which the surgeon will be proposed. 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	

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Expiration Date: 07/31/2020

g) List the name(s) of the transplant hospital(s), applicable dates, program director name(s), the total number of liver transplants, the number of those transplants that were performed in patients under 18 years of age, and the number of 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	Total # LI Transplants	# of LI Transplants in patients under 18 years (included in total)	Total # of LI Procurements
		Start	End					
Fellowship Training								
Experience Post - Fellowship								

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 (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	
Additional Information:	

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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						

Director’s Signature	**Date**
Print Name	

OMB No. 0915-0184
Expiration Date:

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					
21					
2					

2					
23					
24					
25					

Director's Signature	**Date**
Print Name	

OMB No. 0915-0184
Expiration Date:

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

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, co-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 check if the procedure was living donor.

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

#	Date of Surgery	Medical Record#/ OPTN ID #	Surgeon Role: Primary/Co-surgeon/ 1st Assistant (Comments)	Living Donor (Check as applicable)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				

19				
20				

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 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	
Living Donor Liver Recovery Surgeon	
Pediatric Liver Transplant 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) The physician is being proposed as (check all that apply):

Primary Liver Transplant Physician	
Primary Pediatric Liver 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 individual'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 certifications(s). If the physician 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.

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 Liver Transplant Physician**	**Primary Pediatric Liver Transplant Physician**
12-Month Transplant Hepatology Fellowship		
Clinical Experience		
Three-Year Pediatric Gastroenterology Fellowship		
Pediatric Transplant Hepatology Fellowship		
Combined Pediatric Gastroenterology/Transplant Hepatology Training and Experience		
Conditional Approval for Primary 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	**Date** (MM/DD/YY)		**Transplant Hospital**	**Program Director**	**#LI Patients Followed**		
	Start	**End**			**Pre**	**Peri**	**Post**
Experience Post Fellowship							
Fellowship Training							

i) Transplant Training/Experience:
List how the physician fulfills the criteria for participating as an observer of liver transplants and liver 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 LI Transplants Observed**	**# of LI Procurements Observed**

j) 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 if proposed under one of the pediatric pathways or as the primary pediatric transplant physician.

	Describe training and/or experience in each listed area in the past 2 years
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	
Additional Information:	

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

Please complete the following section if the physician being proposed is **different** than the primary liver 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 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). If the physician 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.

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 Gastroenterology Fellowship	
Pediatric Transplant Hepatology Fellowship	
Combined Pediatric Gastroenterology/Transplant Hepatology Training and Experience	
Conditional Pediatric Component Approval – Physician Based	

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 pediatric 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 Pediatric Patients Followed**		
	Start	**End**			**Pre**	**Peri**	**Post**
Experience Post Fellowship							
Fellowship Training							

h) Transplant Training/Experience:
List how the physician fulfills the criteria for participating as an observer of liver transplants and liver 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 LI Transplants Observed**	**# of LI Procurements 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
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	
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. 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						
20						
21						
22						
23						
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 liver transplants and liver procurements. For procurements, the physician must have observed the evaluation, donation process, and management of the donors.

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 #	Living Donor or Deceased	Hospital
1				
2				
3				

Procurements Observed

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

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

Complete this section of the application to describe physicians involved in the program who are not designated as primary, but are credentialed by the transplant hospital to provide transplant services and are 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):

Liver Transplant Physician	
Pediatric Liver 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 individual'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).

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

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 OPTN Bylaws for necessary qualifications and requirements.

Designated Director (insert name): _____	**Y**	**N**
1. 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?		
2. Is a Diplomate of the American Board of Anesthesiology? (if not, see question 3.)		
3. Has the applicant provided letters of recommendation if they are not a Diplomate of the American Board of Anesthesiology? (See Bylaws for requirements)		
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 improvement 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 7: 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 8: 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 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. 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:		