Part 3: Heart Transplant Program

Please check if the transplant program is also applying for the following component.

Pediatric Heart 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: heart transplantation program (P) and/or pediatric transplantation component (C)**. Add additional rows as necessary.

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

~~**DEL**~~	**Name**	**H**	**P**	**Address**	**Phone**	**Fax**	**Email**

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

Name	**H**	**P**	**Address**	**Phone**	**Fax**	**Email**

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

Name	H	P	Address	Phone	Fax	Email

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

Name	H	P	Address	Phone	Fax	Email

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

Name	H	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	H	P	Address	Phone	Fax	Email
*						

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

Name	H	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	H	P	Address	Phone	Fax	Email
*						

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

Name	H	P	Address	Phone	Fax	Email

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

Name	H	P	Address	Phone	Fax	Email

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

Name	H	P	Address	Phone	Fax	Email

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

Name	H	P	Address	Phone	Fax	Email
*						

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

Name	H	P	Address	Phone	Fax	Email

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

Name	Title	H	P	Address	Phone	Fax	Email

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

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

Name	Director of (Program and/or 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 Heart Transplant Surgeon	
Primary Pediatric Heart 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 will be proposed. Refer to the OPTN Bylaws for the necessary qualifications and more specific descriptions of the required supporting documents.

Membership Criteria	
Cardiothoracic Surgery Residency	
Twelve-Month Heart Transplant Fellowship	
Clinical Experience	
Primary Pediatric Transplant Surgeon – Criteria for Full Approval	
Conditional Pediatric Component Approval – Surgeon Based	

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 heart 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	ABTS Approved Program? Y/N	Date (MM/DD/YY)		Transplant Hospital	Program Director	Total # of HR/HL Transplants	# of HR Transplants in patients under 18 years (included in total)	Total # of HR/HL Procurements
		Start	End					
Residency Training								
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	
Recipient Selection	
Donor Selection	
Transplant Surgery	
Post-Operative Hemodynamic Care	
Use of Mechanical Circulatory Assist Devices	
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 heart 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 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

f) Check the applicable pathway(s) 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	
Cardiothoracic Surgery Residency	
Twelve-Month Heart Transplant Fellowship	
Clinical Experience	
Primary Pediatric Transplant Surgeon – Criteria for Full Approval	
Conditional Pediatric Component Approval – Surgeon based	

g) 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 heart 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	**ABTS Approved Program? Y/N**	**Date** (MM/DD/YY)		**Transplant Hospital**	**Program Director**	**Total # of HR/HL Transplants**	**# of HR Transplants in patients under 18 years (included in total)**	**Total # of HR/HL Procurements**
		Start	**End**					
Residency Training								
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	
Recipient Selection	
Donor Selection	
Transplant Surgery	
Post-Operative Hemodynamic Care	
Use of Mechanical Assist Devices	
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						

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**	**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				
22				
2				

3				
24				
25				

Director's Signature	**Date**
Print Name	

Part 3B, Section 3: 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 transplant surgeon:

Name:

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

Date of employment at this hospital:

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

Heart Transplant Surgeon	
Pediatric Heart 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 the surgeon has been recertified, use that date.

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

Part 3C, Section 1: Personnel – Medical – Primary Physician

1. Identify the primary transplant physician:

Name:

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

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

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

Primary Heart Transplant Physician	
Primary Pediatric Heart 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 certification(s). If the physician does not have current American or Canadian board certification, provide letters of recommendation requesting an exception and the plan for continuing education as described in the OPTN Bylaws.

Board Certification Type	Certification Effective Date/	Certification Valid Through Date	Certificate Number

	Recertification Date (MM/DD/YY)	(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	
Twelve-Month Transplant Cardiology Fellowship Pathway	
Clinical Experience	
Conditional Approval for Primary Transplant Physician – *Only available to Existing Programs*	
Primary Pediatric Transplant Physician – Criteria for Full Approval	
Conditional Pediatric Component Approval – Physician Based	

h) Transplant Experience (Post Fellowship) and Training (Fellowship):
List the name(s) of the transplant hospital(s), applicable dates, program director name(s), and the number of transplant patients for which the physician provided substantive patient care (pre-, peri- and post-operatively from the time of transplant) and the number of those patients followed that were under 18 years of age.

Training and Experience	**Date** (MM/DD/YY)		**Transplant Hospital**	**Program Director**	**Total # HR/HL Patients Followed**			**# of HR patients under 18 years followed (included in total)**		
	Start	**End**			**Pre**	**Peri**	**Post**	**Pre**	**Peri**	**Post**
Fellowship Training										
Experience Post Fellowship										

i) Training/Experience:
List how the physician fulfills the criteria for participating as an observer of heart procurements and heart transplants. 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 HR Procurements Observed**	**# of HR Transplants 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 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 Hemodynamic Care	
Post-Operative Immunosuppressive Therapy	
Long-Term Outpatient Follow-Up	
Care of Acute and Chronic Heart Failure	
Use of Mechanical Circulatory Assist Devices	
Donor Selection	
Recipient Selection	
Histologic Interpretation and Grading of Myocardial Biopsies for Rejection	
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 heart 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. Also provide a copy of the certification(s). If the physician does not have current American or Canadian board certification, provide letters of recommendation requesting an exception and the plan for continuing education as described in the OPTN Bylaws.

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

	(MM/DD/YY)		

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	
Twelve-Month Transplant Cardiology Fellowship	
Clinical Experience	
Conditional Approval for Primary Transplant Physician – *Only available to Existing Programs*	
Primary Pediatric Transplant Physician – Criteria for Full Approval	
Conditional Pediatric Component Approval – Physician Based	

g) Transplant Experience (Post Fellowship) and Training (Fellowship):
List the name(s) of the transplant hospital(s), applicable dates, program director name(s), and the number of transplant patients for which the physician provided substantive patient care (pre-, peri- and post-operatively from the time of transplant) and the number of those patients followed that were under 18 years of age.

Training and Experience	**Date** (MM/DD/YY)		**Transplant Hospital**	**Program Director**	**Total # HR/HL Patients Followed**			**# of HR patients under 18 years followed (included in total)**		
	Start	**End**			**Pre**	**Peri**	**Post**	**Pre**	**Peri**	**Post**
Fellowship Training										
Experience Post Fellowship										

h) Training/Experience:
List how the physician fulfills the criteria for participating as an observer of heart procurements and heart transplants. 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 HR Procurements Observed**	**# of HR 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 Hemodynamic Care	
Post-Operative Immunosuppressive Therapy	
Long-Term Outpatient Follow-Up	
Care of Acute and Chronic Heart Failure	
Use of Mechanical Circulatory Assist Devices	
Donor Selection	
Recipient Selection	
Histologic Interpretation and Grading of Myocardial Biopsies for Rejection	
Additional Information	

Table 6: Primary Physician – Recipient Log (Sample)

Organ:	
Name of proposed primary physician:	
Name of transplant hospital where transplants were performed:	
Date range of physician's appointment/training: MM/DD/YY to MM/DD/YY	

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

Complete for all transplants. Please check all phases of care the proposed physician was involved in.						**Patients under 18 years of age only**	
#	**Date of Transplant**	**Medical Record / OPTN ID #**	**Pre-Operative Care**	**Peri-Operative Care**	**Post-Operative Care**	**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							
2							

22							
23							
24							
25							
26							
27							
28							
29							
30							

Director's Signature	**Date**
Print Name	

Table 7: Primary Physician – Observation Log (Sample)

Organ:	
Name of proposed primary physician:	

In the tables below, document the physician's participation as an observer in heart transplants and heart 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. Add rows as needed.

Transplants Observed

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

Procurements Observed

#	Date of Procurement	Medical Record/ OPTN ID #
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 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 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):

Heart Transplant Physician	
Pediatric Heart 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 certification(s).

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

Table 8: Certificate of Investigation

1. List all transplant surgeons and physicians currently involved in the program.

   a) This hospital has conducted its own peer review of all surgeons and physicians listed below to ensure compliance with applicable OPTN Bylaws. Expand rows as needed.

Names of Surgeons

Names of Physicians

   b) If prior transgressions were identified, has the hospital developed a plan to ensure that the improper conduct is not continued?

Yes	
No	
Not Applicable	

   If yes, what steps are being taken to correct the prior improper conduct or to ensure the improper conduct is not repeated in this program? Provide a copy of the plan.

I certify that this review was performed for each named surgeon and physician according to the hospital's peer review procedures.

Signature of Primary Surgeon	**Date**
Print Name	
Signature of Primary Physician	**Date**
Print Name	

Table 9: Program Coverage Plan

1. **Provide a copy of the current Program Coverage Plan** and answer the questions below. The program coverage plan must be signed by either the:

   a. OPTN/UNOS Representative;
   b. Program Director(s); 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:		