Part 3: Lung Transplant Program

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

Pediatric Lung 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: lung transplantation program (L) and/or pediatric transplantation component (P)**.. Add additional rows as necessary.

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

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

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

Name	**L**	**P**	**Address**	**Phone**	**Fax**	**Email**

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

Name	L	P	Address	Phone	Fax	Email

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

Name	L	P	Address	Phone	Fax	Email

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

Name	L	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	P	Address	Phone	Fax	Email
*						

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

Name	L	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	P	Address	Phone	Fax	Email
*						

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

Name	L	P	Address	Phone	Fax	Email

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

Name	L	P	Address	Phone	Fax	Email

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

Name	L	P	Address	Phone	Fax	Email

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

Name	L	P	Address	Phone	Fax	Email
*						

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

Name	L	P	Address	Phone	Fax	Email

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

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

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

Identify the director(s) of the lung 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

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Expiration Date: 07/31/2020

Part 3B: Section 1 - Surgical Personnel, 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 Lung Transplant Surgeon	
Primary Pediatric Lung 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. Also 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	
Cardiothoracic Surgery Residency	
Twelve-Month Lung Transplant Fellowship	
Clinical Experience	
Alternative Pathway for Predominantly Pediatric Programs	

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 transplants and 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	# of LU/HL Transplants	# of LU Procurements
		Start	End				
Residency							
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.

	Describe training and/or experience in each listed area in the past 2 years
Care of Acute and Chronic Lung Failure	
Cardiopulmonary Bypass	
Donor Selection	
Recipient Selection	
Pre- and Postoperative Ventilator Care	
Transplant Surgery	
Postoperative Immunosuppressive Therapy	
Histologic Interpretation and Grading of Lung Biopsies for Rejection	
Long-Term Outpatient follow-Up	
Additional Information	

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

Please complete the following section if the surgeon being proposed is **different** than the primary lung 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. Also 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 could qualify. 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 Lung Transplant Fellowship	
Clinical Experience	
Alternative Pathway for Predominantly Pediatric Programs	

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 transplants and 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	# of LU/HL Transplants	# of LU Procurements
		Start	End				
Residency							
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
Care of Acute and Chronic Lung Failure	
Cardiopulmonary Bypass	
Donor Selection	
Recipient Selection	
Pre- and Postoperative Ventilator Care	
Transplant Surgery	
Postoperative Immunosuppressive Therapy	
Histologic Interpretation and Grading of Lung Biopsies for Rejection	
Long-Term 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.

#	Date of Transplant	Medical Record/ OPTN ID #	Primary Surgeon	1st Assistant	Was the transplant a LU or HL procedure? (Check One)	
					LU	HL
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

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				
23				
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):

Lung Transplant Surgeon	
Pediatric Lung 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/ Recertificatio	Certification Valid Through Date (MM/DD/YY)	Certificate Number

	n Date (MM/DD/YY)		

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 Lung Transplant Physician	
Primary Pediatric Lung 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 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

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

Membership Criteria	
Twelve-Month Transplant Pulmonology Fellowship	
Clinical Experience	
Alternate Pathway for Predominantly Pediatric Programs	
Conditional Approval for Primary Transplant Physician – *Only available to Existing Programs*	

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).

Training and Experience	**Date** (MM/DD/YY)		**Transplant Hospital**	**Program Director**	**# LU/HL Patients Followed**		
	Start	**End**			**Pre**	**Peri**	**Post**
Experience Post Fellowship							
Fellowship Training							

i) Training/Experience:
List how the physician fulfills the criteria for participating as an observer of lung or heart/lung procurements and lung 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 LU/HL Procurements Observed**	**# of LU Transplants Observed**

j) Describe in detail the proposed primary physician'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
Candidate Evaluation Process	
Care of Acute and Chronic Lung Failure	
Cardiopulmonary Bypass	
Donor Selection	
Recipient Selection	
Pre- and Postoperative Ventilator Care	
Postoperative Immunosuppressive Therapy	
Histologic Interpretation and Grading of Lung Biopsies for Rejection	
Long-Term Outpatient Follow-Up	
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 lung 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 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 the applicable pathway(s) through which the physician will be proposed. Refer to the OPTN Bylaws for the necessary qualifications and more specific descriptions of the required supporting documents.

Membership Criteria	
Twelve-Month Transplant Pulmonary Fellowship	
Clinical Experience	
Alternate Pathway for Predominantly Pediatric Programs	
Conditional Approval for Primary Transplant Physician – *Only available to Existing Programs*	

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).

Training and Experience	**Date** (MM/DD/YY)		**Transplant Hospital**	**Program Director**	**# LU/HL Patients Followed**		
	Start	**End**			**Pre**	**Peri**	**Post**
Experience Post Fellowship							
Fellowship Training							

h) Training/Experience:
List how the physician fulfills the criteria for participating as an observer of lung or heart/lung procurements and lung 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 LU/HL Procurements Observed**	**# of LU Transplants Observed**

i) Describe in detail the proposed primary physician'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
Candidate Evaluation Process	
Care of Acute and Chronic Lung Failure	
Cardiopulmonary Bypass	
Donor Selection	
Recipient Selection	
Pre- and Postoperative Ventilator Care	
Postoperative Immunosuppressive Therapy	
Histologic Interpretation and Grading of Lung Biopsies for Rejection	
Long-Term Outpatient Follow-Up	
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.

#	Date of Transplant	Medical Record/ OPTN ID #	Pre-Operative	Peri-Operative	Post-Operative	Was the transplant a LU or HL procedure? (Check One)	
						LU	HL
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
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29							
30							

Director's Signature	**Date**
Print Name	

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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 lung transplants and lung or heart/lung 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 #	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 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):

Lung Transplant Physician	
Pediatric Lung 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**

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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. 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	

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Table 9: 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;
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:		