Department of Health and Human Services
Health Resources and Services Administration

OMB No. 0915-0184
Expiration Date:
XX/XX//2023

OPTN Certificate of Assessment and Program Coverage Plan Membership Application

CERTIFICATION

The undersigned, a duly authorized representative of the applicant, does hereby certify that the answers and attachments to this application are true, correct and complete, to the best of his or her knowledge after investigation. I understand that the intentional submission of false data to the OPTN may result in action by the Secretary of the Department of Health and Human Services, and/or civil or criminal penalties. By submitting this application to the OPTN, the applicant agrees: (i) to be bound by OPTN Obligations, including amendments thereto, if the applicant is granted membership and (ii) to be bound by the terms, thereof, including amendments thereto, in all matters relating to consideration of the application without regard to whether or not the applicant is granted membership.

If you have any questions, please call the UNOS Membership Team at 833-577-9469 or email MembershipRequests@unos.org.

OPTN Representative

Printed Name	**Signature**	**Email Address**

Program Director

Printed Name	**Signature**	**Email Address**

Program Director (if applicable)

Printed Name	**Signature**	**Email Address**

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Program Director (if applicable)

Printed Name	Signature	Email Address

Program Director (if applicable)

Printed Name	Signature	Email Address

Proposed Primary Surgeon

Printed Name	Signature	Email Address

Proposed Primary Physician

Printed Name	Signature	Email Address

Proposed Primary Pediatric Surgeon

Printed Name	Signature	Email Address

Proposed Primary Pediatric Physician

Printed Name	Signature	Email Address

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Part 1: General Information

Name of Transplant Hospital: ____

OPTN Member Code: _____________ **This application corresponds with (select one):**

Hospital Address

Street:____ **Ste:**_________ **Phone #:** ___________________

City: ___________________________ **ST:** __________ **Zip:** ______________ **Fax #:** ______________________

Name of Person Completing Form: _______________________________ **Title:** _______________________

Email Address of Person Completing Form: ____

Date Form is submitted to OPTN Contractor: ______________________________

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Part 2: Certificate of Assessment

The hospital must conduct an assessment of all transplant program surgeons and physicians for any involvement in prior transgressions of OPTN obligations and plans to ensure compliance. The primary surgeon and primary physician are responsible for ensuring the operation and compliance of the program according to the requirements set forth in these Bylaws.

List all surgeons and physicians (primaries, additional and others) involved in the program that the hospital has conducted an assessment for any involvement in prior transgressions of OPTN obligations and plans to ensure compliance. This information is subject to medical peer review confidentiality requirements and must be submitted according to the guidelines provided in the application.

Additional Transplant Surgeons must be credentialed by the transplant hospital to provide transplant services and be able to independently manage the care of transplant patients, including performing the transplant operations and organ procurement procedures.

Additional Transplant Physicians must be credentialed by the transplant hospital to provide transplant services and be able to independently manage the care of transplant patients.

A surgeon or physician employed by the transplant hospital that does not independently manage the care of transplant patients may be listed as **other**.

List all surgeons and physicians involved in the transplant program. For any surgeon or physician listed as 'Primary', complete the corresponding application for that individual. For each surgeon or physician listed as 'Additional', provide a credentialing letter for each proposed individual:

Name	*NPI#*	*Surgeon or Physician?*	*Primary, Additional, or other?*	*OPTN Transgressions? **

**If OPTN transgressions are identified for any individual, what is the program's plan to ensure compliance?*

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Part 3: Program Coverage Plan

The Program Coverage Plan must describe how continuous medical and surgical coverage is provided by transplant surgeons and physicians who have been credentialed by the transplant hospital to provide transplant services to the program.

The Program Coverage Plan must address all the following requirements

By checking the box below, the program attests to the following:

Patient Notification

☐ *The transplant program provides patients with a written summary of the Program Coverage Plan when placed on the waiting list and when there are any substantial changes in the program or its personnel.*

For the following questions, check Yes or No:

Transplant Surgeons

Yes No

☐ ☐ *Is a transplant surgeon readily available in a timely manner to facilitate organ acceptance, procurement, and transplantation?*

☐ ☐ *Is this a single surgeon program?* **If yes, provide a copy of the patient notice or protocol for providing patient notification.**

☐ ☐ *Does the transplant program have transplant surgeons available 365 days a year, 24 hours a day, 7 days a week to provide program coverage?* ***If the answer is no, provide a written explanation in the Program Coverage Plan that justifies the current level of coverage.***

☐ ☐ *Will any of the transplant surgeons be on call simultaneously at two transplant programs more than 30 miles apart?* ***If the answer is yes, the program must request an exemption from the MPSC to operate as a transplant program sharing primary personnel with another transplant hospital, without additional transplant staff.***

☐ ☐ *Is the primary surgeon designated as the primary surgeon at more than one transplant hospital?* ***If yes, answer the question below.***

Yes No

☐ ☐ *Do you have additional surgeons listed with the program?*

If the answer is no, the program must request an exemption from the MPSC to operate as a transplant program sharing primary personnel with another transplant hospital, without additional transplant staff.

Transplant Physicians

Yes No

☐ ☐ *Is this a single physician program?* ***If yes, provide a copy of the patient notice or protocol for providing patient notification.***

☐ ☐ *Does the transplant program have transplant physicians available 365 days a year, 24 hours a day, 7 days a week to provide program coverage?* ***If the answer is no, provide a written explanation that justifies the current level of coverage.***

☐ ☐ *Will any of the transplant physicians be on call simultaneously for two transplant programs more than 30 miles apart?* ***If the answer is yes, the program must request an exemption from the MPSC to operate as a transplant program sharing primary personnel with another transplant hospital, without additional transplant staff.***

☐ ☐ *Is the primary physician designated as the primary physician at more than one transplant hospital?* ***If yes, answer the questions below.***

> **Yes No**
>
> ☐ ☐ *Do you have additional physicians listed with the program?*
>
> ***If the answer is no, the program must request an exemption from the MPSC to operate as a transplant program sharing primary personnel with another transplant hospital, without additional transplant staff.***

Attach the Program Coverage Plan to the application. The Program Coverage Plan must include notification patients receive when they are placed on the waiting list and when there are any substantial changes in the program or its personnel.

PUBLIC BURDEN STATEMENT

The private, non-profit Organ Procurement and Transplantation Network (OPTN) collects this information in order to perform the following OPTN functions: to assess whether applicants meet OPTN Bylaw requirements for membership in the OPTN; and to monitor compliance of member organizations with OPTN Obligations. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this information collection is 0915-0184 and it is valid until XX/XX/2023. This information collection is required to obtain or retain a benefit per 42 CFR §121.11(b)(2). All data collected will be subject to Privacy Act protection (Privacy Act System of Records #09-15-0055). Data collected by the private non-profit OPTN also are well protected by a number of the Contractor's security features. The Contractor's security system meets or exceeds the requirements as prescribed by OMB Circular A-130, Appendix III, Security of Federal Automated Information Systems, and the Departments Automated Information Systems Security Program Handbook. The public reporting burden for this collection of information is estimated to average 3 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including

suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N136B, Rockville, Maryland, 20857 or paperwork@hrsa.gov.