Department of Health and Human Services
Health Resources and Services Administration

OMB No. 0915-0184
Expiration Date: xx/xx/20xx

OPTN Individual Membership Application

CERTIFICATION

The undersigned 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.

Individual Membership Applicant

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

Part 1: General Information

Name of Individual Applying: _____

Address: ☐ Home ☐ Business

Street: _____ Suite: _____ Phone #: _____

City: _____ State: _____ Zip: _____Fax #: _____

Email Address: _____

Date Form is submitted to OPTN Contractor: _____

Applying for:

☐ New Membership

☐ Membership Renewal

Part 2: General Requirements

Check all that apply.

☐ *I have served or am presently serving on the OPTN Board of Directors or an OPTN committee.*

☐ *I am a transplant candidate, recipient, or organ or tissue donor.*

☐ *I am the family member of a transplant candidate, recipient, or organ or tissue donor.*

☐ *I am presently employed by an organ procurement organization (OPO), transplant hospital, or histocompatibility laboratory member.*

☐ *I am presently an independent contractor to an organ procurement organization (OPO), transplant hospital, or histocompatibility laboratory member.*

☐ *I am a former employee of an OPO, transplant hospital, or histocompatibility laboratory members.*

☐ *I am a former independent contractor for an OPO, transplant hospital, or histocompatibility laboratory members.*

☐ *I am a former employee of Federal or State government agency involved in organ donation or transplantation, and who demonstrates continued interest and involvement in organ donation or transplantation.*

☐ *I do not meet any of the criteria listed above but I have an active interest and involvement in organ donation or transplantation.*
If this box is checked, provide at least three letters of recommendation, written by three different OPTN individual members, that demonstrate your active interest and involvement in organ donation or transplantation .

Provide an explanation for why the individual would like to be a new or renewing member of the OPTN:

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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/20xx. 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 0.25 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.