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

OPTN Representative Form

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.

Instructions:

For changes to the positions in this form, the current OPTN Representative, Alternate OPTN Representative, or Organization CEO must sign. The new individual being designated cannot provide the signature.

CEOs should sign-off on forms for new OPTN members.

OPTN Representative

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

Alternate OPTN Representative

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

Organization CEO

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

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Part 1: General Information

Name of Organization: _____

OPTN Member Code (4 Letters): _____

Office Address

Street: _____ Suite: _____ Phone #: _____

City: _____ State: _____ Zip: _____

Mailing Address (if different from Office Address)

Street/P.O. Box: _____

City: _____ State: _____ Zip: _____

Name of Person Completing Form: _____ Title: _____

Email Address of Person Completing Form: _____

Date Form is submitted to OPTN Contractor: _____

Part 2: OPTN Representatives

OPTN Representative

Name: _____ Job Title: _____

Credentials (list all): _____

Street: _____ Suite: _____ Phone #: _____

City: _____ State: _____ Zip: _____

Email Address: _____

OPTN Alternate Representative

Name: _____ Job Title: _____

Credentials (list all): _____

Street: _____ Suite: _____ Phone #: _____

City: _____ State: _____ Zip: _____

Email Address: _____

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 membership requirements; 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 0.43 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 Information Collection Clearance Officer, 5600 Fishers Lane, Room 14N39, Rockville, Maryland, 20857 or paperwork@hrsa.gov.