	WMDA Transplant Center Evaluation Form			
	Document type	Form	WG/Committee	WGQR
	Document reference	WMDA Transplant Center Evaluation	Approved by	
	Version	1	Approval date	
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WMDA Transplant Center Evaluation Form

This form is completed by TCs that are not represented by a national registry for international searching for the purpose of obtaining access to WMDA Search & Match Service. The purpose of this form is to evaluate your center's hematopoietic stem cell transplant (HSCT) experience. WMDA-affiliated registries may use the results of this evaluation (if the TC elects to make this information available) in lieu of their own requirements to determine whether the TC can search their donor/cord blood registry. If your center is already an affiliated member of a WMDA qualified or accredited registry, it is not necessary to complete this form.

NOTE: If your center is currently FACT-JACIE accredited for allogeneic transplantation, please e-mail a copy of your FACT-JACIE certificate and the form with the following sections (marked by *) filled.

General Information*

Transplant Center Medical Director*

Primary Contact Person (Coordinator)*

Back-up Coordinator*

Emergency contacts*

Abbreviations used in this form:

HSCT Hematopoietic Stem Cell Transplant

HPC(A) Hematopoietic Progenitor Cells, Apheresis [*also known as peripheral blood stem cells or PBSC*]

HPC(CB) Hematopoietic Progenitor Cells, Cord Blood

HPC(M) Hematopoietic Progenitor Cells, Marrow

TC Transplant Center

General Information*

Legal name of TC:

If applicable, English name of TC and/or abbreviation:

Mailing address:

City:

Postal code:

Country:

Website:

Transplant Center Medical Director*

First name:

Degree(s):

Surname:

Title:


Mailing address:

City:

Postal code:

Country:

E-mail:

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Office phone number:	Mobile number:	Fax number:
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Primary Contact Person (Coordinator)*

First name:	Degree(s):
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Surname:	Title:
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Mailing Address:

City:	Postal code:
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Country:	E-mail:
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Office phone number:	Mobile number:	Fax number:
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Is Contact Person/Coordinator proficient in English? <i>Required: Yes</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Facility Description

1.	Which year(s) did the HSCT unit at your TC begin performing autologous and allogeneic transplants? Autologous:_____ Allogeneic:_____
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2.	Center accepts (check one): <input type="checkbox"/> Adult patients only <input type="checkbox"/> Pediatric patients only <input type="checkbox"/> Adult and pediatric patients
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3.	Please indicate the number of beds on the inpatient HSCT unit: Number of adult beds:_____ Number of pediatric beds: _____
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4.	Are there defined practices to minimize the risk of airborne contamination in inpatient rooms? Please describe details. <i>Required: Yes</i> <input type="checkbox"/> Yes <input type="checkbox"/> No Details:
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5.	Do all patient treatment areas (both inpatient and outpatient/clinic areas) have processes in place to minimize the risk of spreading infection? <i>Required: Yes</i> <input type="checkbox"/> Yes <input type="checkbox"/> No
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6.	Please provide copies of any licenses, accreditations, or certificates by your national government (if applicable) and/or other agency relevant to authorizing your center to perform HSCT transplants at your institution. <i>Required: Yes, if applicable</i>
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<input type="checkbox"/> Attached items:	<input type="checkbox"/> No attachment, please comment:
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7.	List the number of patients who received transplants in each of the last 2 full calendar years and in the current year to date by stem cell source: <i>Information only</i>			
	YEAR	Autologous HPC(M)/HPC(A)	Related (including haploidentical) HPC(M)/HPC(A)/HPC(CB)	Unrelated HPC(M)/HPC(A)/HPC(CB)
	Current year to date			

8.		For adults:	For pediatrics:
	What is the one year overall survival rate for patients at your TC after allogeneic transplantation? Please provide separate survival rates for adult versus pediatric patients, if applicable. <i>Recommended: $\geq 50\%$ at one year</i>	1 year:	1 year:
		3 years:	3 years:


Personnel / Transplant Team

9.	Identify the transplant physicians involved in the program, the number of years each physician has spent at your program, and their overall experience with allogeneic HSCT. Please attach the CV of the Transplant Center Medical Director. If there are more than two physicians in addition to the TC Medical Director, please attach the information in a separate document. <i>Required: Medical Director must have at least two years of allogeneic HSCT including at least one year of unrelated donor experience and one additional physician must have at least one year of allogeneic HSCT experience</i>		
		For adults:	For pediatrics:
	First name:		
	Surname:		
	Years of allogeneic HSCT experience:		
	Years of unrelated HSCT experience:		
	Years at this HSCT program:		

	Medical Director?	<input type="checkbox"/> This is the medical director and CV is enclosed.	This is the medical director and CV is enclosed.
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	Additional physician first name:		
	Additional physician surname:		
	Years of allogeneic HSCT experience: <i>Required: 1 year</i>		
	Years at this HSCT program:		
	Additional physician first name:		
	Additional physician surname:		
	Years of allogeneic HSCT experience: <i>Required: 1 year</i>		
	Years at this HSCT program:		
10.	Is there physician coverage 24 hours per day, seven days per week? <i>Required: Yes</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No, please comment:	
11.	HSCT team has nurses with specialized HSCT training and experience: <i>Required: Yes</i>	<input type="checkbox"/> Yes (adults) <input type="checkbox"/> Yes (peds) <input type="checkbox"/> No, please comment:	
12.	Is there a designated, trained backup coordinator and/or other designated personnel proficient in English and available to provide daily and emergency communication? <i>Required: Yes</i>		
	<input type="checkbox"/> Yes <input type="checkbox"/> No, please comment:		
	Please provide information on the back-up Coordinator(s)*		
		Back-up Coordinator	
	First name:		
	Surname:		
	E-mail:		
	Phone number:		
	Job title:		


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13.	Please list contact information for the registry to reach two emergency contacts, including after-hour phone number(s), mobile phone(s) or a general 24-hour department phone number, as appropriate. Emergency contacts can be any English speaking person on the team, including the medical director or coordinator.*		
		Emergency contact # 1	Emergency contact # 2
	First name:		
	Surname:		
	Phone number:		
	Mobile number:		
	24-hr or HSCT inpatient phone number:		
	After hours E-Mail:		
14.	<p>Does TC have readily-available internet access for exchange of vital information including search results, transplant logistics, and other essential points of communication? <i>Required: Yes</i></p> <p> <input type="checkbox"/> Yes <input type="checkbox"/> No (specify alternate means of contact): </p>		
Support Services			
15.	<p>Your TC must have support from an HLA laboratory that will be used for verification typing. Please list the name and location of the HLA laboratory that will be used for intermediate or high-resolution typing, and indicate if the laboratory is accredited for clinical typing by an agency such as the American Society of Histocompatibility and Immunogenetics (ASHI), European Foundation for Immunogenetics (EFI), College of American Pathologists (CAP) or other agency. The laboratory may or may not be affiliated with your transplant hospital.</p> <p><i>Required: Accreditation by an established accrediting agency</i></p>		
	HLA laboratory name:		
	<input type="checkbox"/> Laboratory accreditation certificate attached.		
	<input type="checkbox"/> No certificate attached, please explain:		

Policies and Administration

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19.	<p>Your TC must have defined criteria that outline diagnostic categories for which unrelated HSCT is an acceptable treatment option. Please provide your policy or procedures outlining diagnostic categories for which HSCT is an acceptable treatment. <i>Required: TC must have defined criteria</i></p> <p> <input type="checkbox"/> Document attached or describe in comment box. <input type="checkbox"/> Other criteria used (e.g. EBMT, BSMT, ASBMT, etc): describe in comment box. <input type="checkbox"/> No policy available. </p>	
20.	<p>Your TC must have criteria for an acceptable level of HLA matching between patient and donor for the purpose of unrelated hematopoietic stem cell donation. Please provide documented policy that outlines the acceptable level of matching between patient and donor for acceptable disease indications. <i>Required: TC must have defined criteria</i></p> <p> <input type="checkbox"/> Document attached or describe in comment box. <input type="checkbox"/> Other published standards used: describe in comment box. </p>	
21.	<p>Does your TC have a policy for reporting serious adverse events? <i>Required: Yes</i></p> <p> <input type="checkbox"/> Yes <input type="checkbox"/> No </p>	
22.	<p>Does your TC have a policy to protect patient and donor confidentiality? <i>Required: Yes</i></p> <p> <input type="checkbox"/> Yes <input type="checkbox"/> No </p>	
23.	<p>Does your center have professional and general liability insurance? <i>Recommended: Should be yes</i></p> <p> <input type="checkbox"/> Yes <input type="checkbox"/> No, please explain: </p>	
24.	<p>Does your transplant center have an informed consent procedure for patients undergoing an international unrelated donor and cord blood unit search?</p> <p><i>Required: Yes</i></p>	<p> <input type="checkbox"/> Yes <input type="checkbox"/> No </p> <p>Comments:</p>

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Declaration

As the responsible Transplant Center Medical Director, I declare that the information provided on this form is accurate and correct.

I will notify the WMDA of any significant changes in personnel, facility, accreditation status or support that may have an impact to the activities of the transplant center.

- ☐ I agree that the information given in this form and the final decision is published in the membership section of the WMDA website. This allows other registries to approve search requests from my TC without performing a new evaluation.
- ☐ I do not agree that the information given in this form and the final decision is published in the membership section of WMDA.

Date:

(yyyy/mm/dd)

Signature:

Please submit this form to the World Marrow Donor Association (WMDA, mail@wmda.info).