PRINT RESET

WMDA	Transplant Center Evaluation Form (any Registry)			
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Transplant Center Evaluation Form (any Registry)

Please complete this form, which will be used by _____ [*Registry name*] to evaluate your center's hematopoietic stem cell transplant (HSCT) experience.

The criteria and evaluation process are intended to identify TCs with appropriate experience and infrastructure to pursue hematopoietic stem cell transplantation (HSCT) of an unrelated donor hematopoietic stem cell (HSC) product or cord blood unit. In addition, per WMDA Standard section 1, the evaluation process also serves to ensure that transplant center processes comply with the relevant requirements from the WMDA Standards.

The data provided is used to evaluate your transplant center's experience with unrelated transplantation and to approve your participation in international stem cell product exchange with stem cell donor registries and cord blood banks. It will be stored by the registry as long as the affiliation between the centers is actively ongoing.

Items reviewed include:

1. TC must use patient treatment areas (both inpatient and outpatient/clinic areas) that minimize the risk of infection.
2. TC must be appropriately registered, licensed, or accredited by its national government (if applicable) and/or other agency relevant to HSCT.
3. TC's overall survival rate for patients (both adult and pediatric as applicable) should be $\geq$ 50% at one year after allogeneic transplantation;
4. TC Medical Director must have at least two years of allogeneic HSCT experience, including at least one year of experience with unrelated donor transplantation, in his/her career. TC must provide a curriculum vitae of the Medical Director(s) that will be stored only for the duration of the review process.
5. TC must have at least one additional physician that has a minimum of one year of allogeneic HSCT experience.
6. TC must provide physician coverage 24 hours per day, seven days per week.
7. TC must have a transplant team that includes nurses with training and experience in the care of transplant patients.
8. TC must have a coordinator or other key personnel proficient in English and available to provide daily and emergency communication.
9. TC must have support from an HLA laboratory that is accredited by an established accrediting agency.
10. TC must have support from an IDM laboratory that is accredited by an established national agency.
11. TC must have support from a stem cell processing laboratory that is accredited by an established national agency and has the capability to perform product testing functions.
12. TC should identify a specific outcome registry to which they report patient outcomes.
13. TC must adhere to applicable WMDA Standards.
14. TC must have a policy regarding research studies and information to the registry.
15. TC must have a policy outlining diagnostic indications acceptable for unrelated HSCT.
16. TC must have a policy for an acceptable level of HLA matching between patient and donor for purpose of unrelated HSCT.
17. TC must have a policy for reporting serious adverse events.
18. TC must have a policy for protecting donor and patient confidentiality.
19. TC should have proof of insurance for professional and general liability.
20. TC must provide an empty copy of the patient informed consent used for unrelated donor searches.

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*
Personnel / Transplant Team *

General Information *		
1.	Legal name of TC:	
	If applicable, English name of TC and/or abbreviation:	
	Mailing address:	
	City:	Postal code:
	Country:	Fax number (optional):
Facility Description		
2.	Which year(s) did the HSCT unit at your TC begin performing autologous and allogeneic transplants? Autologous:_____ Allogeneic:_____	
3.	Center accepts (check one): ☐ Adult patients only ☐ Pediatric patients only ☐ Adult and pediatric patients	
4.	Please indicate the number of beds on the inpatient HSCT unit: Number of adult beds: _____ Number of pediatric beds: _____	
5.	Are there defined practices to minimize the risk of airborne contamination in inpatient rooms? ☐ No ☐ Hepa filter ☐ Positive air pressure ☐ Other:_____	
6.	Do all patient treatment areas (both inpatient & outpatient/clinic areas) have processes in place to minimize the risk of spreading infection? ☐ Yes ☐ No , please comment:	

7.

Please provide copies of any licenses, accreditations, or certificates by your national government (if applicable) and/or other agency relevant to your transplant center.

☐ JACIE Accreditation

☐ Accreditation by national body: _____

☐ No accreditation, please explain :

8.

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**:**

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			

9.

What is the 1 and 3 year overall survival rate for **ADULT PATIENTS** at your TC after allogeneic Transplantation? (State N/A if not applicable): 1 year: _____ 3 years: _____

10.

What is the 1 and 3 year overall survival rate for **PEDIATRICS PATIENTS** at your TC after allogeneic Transplantation? (State N/A if not applicable): 1 year: _____ 3 years: _____

Personnel / Transplant Team *

11. 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 (CV will be deleted after review).** If there are more than two physicians in addition to the TC Medical Director, please provide the information separately.
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

	For adults:	**For pediatrics:**
Medical Director (First and Last name)		
Years of allogeneic HSCT experience:		
No. of related HSCT supervised:		
No. of unrelated HSCT supervised:		
Office phone no. :		
Mobile phone no. :		
E-mail address:		
CV of Medical Director attached:	☐ **CV is enclosed**	☐ **CV is enclosed**
Additional physician #1 (First and Last name)		
Year of allogeneic HSCT experience:		
Year at this Transplant Center:		
Additional physician #2 (First and Last name)		
Year of allogeneic HSCT experience:		
Year at this Transplant Center:		

12. Is there physician coverage 24 hours per day, seven days per week?

☐ Yes ☐ No

If No, please comment:

13. HSCT team has nurses with specialized HSCT training and experience:

☐ Yes (adults) ☐ Yes (peds) ☐ No

If No, please comment:

14. Is there a designated, trained coordinator(s) and/or other designated personnel proficient in English and available to provide daily and emergency communication?

☐ Yes ☐ No, please comment:

Please provide information on the Coordinator(s)*

	Coordinator #1	**Coordinator #2** (if applicable)
First and Last name:		
E-mail:		
Mobile phone no. :		
Job title:		

15 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** (if applicable)
First and Last name:		
E-mail:		
Mobile phone no:		
24-hr or HSCT inpatient phone		
After hours E-mail		

Support Services		
16.	Your TC must have support from an HLA laboratory that will be used for patient typing and patient verification typing as well as donor verification typing, at a minimum HLA-A, -B, -C, -DRB1 at high resolution. The laboratory must be 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 accreditation must be up-to-date and valid. Please provide the following information regarding your HLA laboratory: ☐ HLA Laboratory has accreditation from (agency): ☐ HLA Laboratory is not accredited, please explain:	
17.	Your TC must have support from an IDM (Infectious Disease Markers) laboratory that is accredited by a national authority. The accreditation must be up-to-date and valid. Please provide the following information regarding your IDM laboratory**:** ☐ IDM laboratory has accreditation from (agency)**:** ☐ IDM laboratory is not accredited, please explain**:**	
18.	Your TC must have support from an accredited stem cell processing laboratory. The accreditation must be up-to-date and valid. Please provide the following information regarding your stem cell processing laboratory: ☐ Stem cell processing laboratory has accreditation from (agency): ☐ Stem cell processing laboratory is not accredited, please explain:	
	Laboratory capabilities and type of processing performed	a. Count number of nucleated cells and/or quantify CD34+ cells in HPC(A) products received: ☐ Yes ☐ No b. Confirm ABO grouping and Rh typing of HPC(M) or HPC(A) products received: ☐ Yes ☐ No c. Perform fungal and bacterial cultures on products received: ☐ Yes ☐ No

Policies and Administrations	
19.	Please indicate to which outcome registry you're TC is reporting your patients' outcome data: ☐ Australian Bone Marrow Transplant Recipient Registry (www.abmtrr.org) ☐ Asia Pacific Blood and Marrow Transplantation Group (www.apbmt.org) ☐ Center for International Blood and Marrow Transplant Research (CIBMTR) (www.cibmtr.org) ☐ European Group for Blood and Marrow Transplantation (EBMT) (www.ebmt.org) ☐ Eastern Mediterranean Blood and Marrow Transplantation Group (www.embmt.org) ☐ Latin America Blood and Marrow Transplantation Group (LABMT) ☐ Other (Specify): *Recommended: Should identify a specific outcome registry (US donor requirement to report to EBMT or CIBMTR).* If your TC is not currently reporting outcome data, what is your plan moving forward?
20.	Your TC is required to adhere to applicable WMDA Standards. The WMDA Standards can be found at: https://www.wmda.info/professionals/quality-and-accreditation/wmda-standards/ Have key transplant center personnel read, understood, and agreed to adhere to the applicable WMDA Standards? ☐ Yes ☐ No If No, please explain:
21.	Research studies requiring additional testing of donor samples or additional information about the donor require approval by the registry and can only be requested in case of institutional review board (IRB) approved research studies. Does your center have a policy in place for research studies? ☐ Yes ☐ No If No, please explain:
22.	Your TC must have a policy specifying diagnostic indications that your center accepts for HSCT. Please provide your policy or procedures outlining diagnostic categories for which HSCT is an acceptable treatment ☐ EBMT Criteria ☐ National standards/guidelines for HSCT (described in comment box) ☐ TC has established criteria, document attached:

23.	Your TC must have criteria for an acceptable level of HLA matching between patient and donor for the purpose of unrelated HSC donation. Please provide documented policy that outlines the acceptable level of matching between patient and donor for acceptable disease indications. ☐ Document attached or described in comments box: ☐ Other published standards used (described in comment box):
24.	Does your TC have a policy for reporting serious adverse events? ☐ Yes ☐ No If No, please explain:
25.	Does your TC have a policy to protect patient and donor confidentiality? ☐ Yes ☐ No If No, please explain:
26.	Does your center have professional and general liability insurance? ☐ Yes ☐ No If No, please explain:
27.	Your transplant center is responsible for obtaining valid signed informed consent from a patient before the start of an unrelated donor search. This consent must include information about the international donor search procedure as well as consent for the required transfer of personal and medical data. Please provide an empty copy of the implemented consent form ☐ Consent attached ☐ No consent attached Please explain:

Declaration		
As the responsible Transplant Center Medical Director, I declare that the information provided on this form is accurate and correct. I will notify _____ [*Registry name*] of any significant changes in personnel, facility, accreditation status or support that may have an impact to the activities of the transplant center.		
Date: (yyyy-mm-dd)	Name:	Signature:

Please submit this form to the registry / organization that sent you this evaluation form.

Registry / organization's name: _____

E-mail: _____

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