PRINT RESET

WMDA	WMDA TC Evaluation Reviewer Checklist			
	Document type	Form	Approved by	
	Document reference	WMDA TC Evaluation Reviewer Checklist	Approval date	20230713
	Version	1.0	Approval status	
	Pillar / Scope	P2	Status	Public

WMDA Office					
Applicant Transplant Center Name:					
Registry Name (if applicable):					
Reviewer Name:					
Review Date:					
CRITERIA ASSESSMENT (indicate if criteria has been met)		**Yes**	**No**	**N/A**	**Comments**
General Information					
1.	Mailing address	☐	☐	☐	
Facility Description		**Yes**	**No**	**N/A**	
2.	Year HSCT program began performing allogeneic transplants. *Information Only*	☐	☐	☐	
3.	Adults and/or pediatric patients. *Information Only*	☐	☐	☐	
4.	Indicate number of beds for each adult and pediatrics. *Information Only*	☐	☐	☐	
5.	Inpatient rooms have defines practices to minimize the risk of airborne contamination. *Must be yes*	☐	☐	☐	
6.	All patient treatment areas (both inpatient and outpatient/clinic) minimize the risk of infection. *Must be yes*	☐	☐	☐	

7	Registration, license, or accreditation certificate(s) by national government (if applicable) and/or other agency relevant to HSCT. *Certificate(s) must be attached and current if applicable*	☐	☐	☐	
8.	List the number of patients who received transplants in each of the last two years by stem cell source. *Information only*	☐	☐	☐	
9. **10.**	Survival rate for patients (both adult and pediatric as applicable) should be ≥50% at one year after allogeneic transplantation. *Discuss with WMDA clinical reviewer or registry physician if fewer than 5 allo transplants and/or survival rate is less than 50%*	☐	☐	☐	
Personnel / Transplant Team		**Yes**	**No**	**N/A**	
11.	Medical Director has at least two years of allogeneic HSCT experience, including one year of unrelated donor transplantation experience, in his/her career. Contact details are indicated. *Must be yes AND copy of CV must be attached*	☐	☐	☐	
	At least one additional physician has a minimum of one year of allogeneic HSCT experience. *Must be yes*	☐	☐	☐	
12.	Physician coverage 24 hours per day, seven days per week. *Must be yes*	☐	☐	☐	
13.	Transplant team includes nurses with training and experience in the care of transplant patients. *Must be yes*	☐	☐	☐	

14.	Coordinator or other key personnel proficient in English and available to provide daily and emergency communication and logistical coverage. *Must be yes*	☐	☐	☐	
15.	Designated backup coordinator name and contact information. *Information Only*	☐	☐	☐	
	Emergency/afterhours contact information provided. *Must be yes*	☐	☐	☐	
Support Services		**Yes**	**No**	**N/A**	
16.	Support from an HLA laboratory that is accredited by an established accrediting agency. *Lab accreditation agency should be indicated*	☐	☐	☐	
17.	Support from an IDM (Infectious Disease Markers) laboratory that is accredited by a national authority. *Lab accreditation agency should be indicated*	☐	☐	☐	
18.	Support from an accredited stem cell processing laboratory that has capability to perform all 3 designated functions. *Lab accreditation agency should be indicated ;* *Must be yes to all 3 laboratory functions*	☐	☐	☐	
Policies and Administration		**Yes**	**No**	**N/A**	
19.	Willing to comply with designated patient outcome reporting policies to established outcomes registry. *Should be yes*	☐	☐	☐	
20.	Adheres to applicable WMDA Standards. *Must be yes*	☐	☐	☐	

21.	Policy for research studies in place. *Should be yes*	☐	☐	☐	
22.	Defined criteria outlining diagnostic categories acceptable for unrelated HSCT. *Must be yes AND policy attached or identification of other criteria used (e.g., EBMT, ASBMT, etc)*	☐	☐	☐	
23.	Defined criteria for acceptable level of HLA matching between patient and donor. *Must be yes AND policy/document attached*	☐	☐	☐	
24.	Policy for reporting serious adverse events. *Must be yes*	☐	☐	☐	
25.	Policy for protecting donor and patient confidentiality. *Must be yes*	☐	☐	☐	
26.	General and professional liability insurance. *Should be yes*	☐	☐	☐	
27.	Consent form that includes information about the international donor search procedure as well as consent for the required transfer of personal and medical data is attached. *Must be yes*	☐	☐	☐	

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Conclusions			
Recommendation	☐ Approve ☐ Deny ☐ Request additional information		
Additional information requested *(specify):*			
Additional comments:			
Reviewer Name:	Reviewer title:	Date:	Signature: