佛教慈濟骨髓幹細胞中心
Buddhist Tzu Chi Stem Cells Center
Application for participation as a transplant center

Name of Transplant Center: ____

Contact Physician:
(Program Director) ______________________________________ **Degree:**_________________

Government Certified: ☐ **Yes** ☐ **No**
If yes, in which subspecialty(ies): ____

Mailing Address: ____

____

____

TEL: ______________________________ **Fax :** _________________________ **(24hr available)**

E-mail Address: ____

Contact Person: ___________________________ **Job Title:** _____________________________

Mailing Address: ____

____

____

TEL: ______________________________ **Fax :** _________________________ **(24hr available)**

E-mail Address: ____

970 花蓮市中央路三段 707 號 E-mail：btcscc@tzuchi.com.tw
Tel：886-3-8561825 Ext：3518/3519/3216 Fax：886-3-8572614
707 Sec. 3, Chung Yang Road, Hualien, Taiwan 970, R.O.C.

FACILITY DESCRIPTION

1. **Program Development/Facilities:**

   1.1.When was your stem cell transplant program established?

   1.2.Describe the development of your stem cells transplant program including expansion of unit size and medical staff, patient population served (i.e., geographic areas), and referral sources.

   1.3.Is this application for an adult unit, pediatric unit, or both? An institution with both adult and pediatric components may apply as a single center provided the patient care units demonstrate functional unity through shared mechanisms such as:

   - **medical director**
   - **coordinator**
   - **standards operating policies and procedures**
   - **data management**
   - **cell processing laboratory**
   - **training of support personnel**

   If the patient care units are located in more than one institution, at least one institution shall satisfy all transplant center participation criteria individually. Patient care units at any other institution shall have performed a minimum of four allogeneic transplants within the previous 12 months.

   If multiple units are being considered in this application, the response to each question should clearly indicate the differences or commonalities between the units.

   1.4.Does your program have a designated transplantation unit? If so, please indicate the number of beds, air handling system, nurse-to-patient ratio, nursing training and allogeneic transplant experience.

   1.5.List any peer-reviewed publications regarding allogeneic hematopoietic transplants from your center.

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1.6.Please attach a copy of the certificate from the local accreditation of health-care organization.

2. Stem Cell Transplant Experience

2.1.Document your center's experience (for the latest 5 years) in the number of patients transplanted each year according to the source of the stem cells:

	Autologous	Sibling	MUD		
Year	Marrow/PBSC	Marrow/PBSC	Marrow/PBSC	Cord Blood	DLI

1.2.Please use the enclosed Hematopoietic Stem Cell transplant History form to describe allogeneic transplant activity at your institution during the past two years to document that your center has performed at least 10 primary allogeneic transplants (for at least 10 different patients) per year during the previous 24 months or at least 20 primary allogeneic transplants (for at least 20 different patients) during the past 12 months. Separate history forms should be used if the application is for separate patient care units (e.g, adult and pediatric). The application will not be considered until the =100 day status is documented for all recipients.

PERSONNEL/TRANSPLANT TEAM

Describe the stem cell transplant team(number of physicians, physician assistants, transplant coordinators, pharmacists, social services, dietetics, data management, etc.). Identify the transplant physicians involved in the program, the year each physician joined the team, and their experience with allogeneic transplants. Please attach curriculum vitae of the Program

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Director (BTCSCC contact physician):

Team Member	Expertise/Speciality	Data Started with this team	#of years experience with Allogeneic Tx

Support Services

1. **BTCSCC transplant centers must perform confirmatory HLA typings of the intended donor/recipient pair at the same laboratory. Describe the histocompatibility laboratory support provided to your program for both Class I (high resolution) and Class II (high resolution) HLA typing.**
2. **Describe the support of transfusion services, HLA testing laboratory and clinical laboratory provided to the program. Attachments of letters of support from the responsible heads and their curriculum vitaes are appreciated.**
3. **Does your center have experienced physicians who provide consultative services in at least the following disciplines: surgery, pulmonary medicine, intensive care, gastroenterology, nephrology, infectious diseases, cardiology, pathology, psychiatry, and radiation therapy?**
4. **Does your center have sufficient staff experienced in allogeneic transplantation from at least the following services: pharmacy, dentistry, dietary, social services and physical therapy?**
5. **Are you willing to comply with BTCSCC patient outcome reporting policies listed below? A copy of the BTCSCC Patient Post-Transplantation Follow-up Form should be filled out and faxed back to us at Transplant day 100, and 1~7 year anniversary post transplant.**
6. **Will the unrelated transplant coordinator be responsible for completing the required data and follow-up forms? Will this person have sufficient time available to complete the required data forms and submit them with readily available access to necessary**

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communication facilities, e.g, fax or personal computers?

STANDARD OPERATING PROCEDURES

1. **Are there standard operating procedures (SOPs) that address at least the following?**
   - **Infection prevention and control**
   - **Hematopoietic progenitor cell infusion**
   - **Blood component transfusion**

Please enclose a copy of the SOPs Table of Contents and indicate the date of last review.

2. **Please enclose a copy of your institution's clinical guidelines, procedures and/or protocols that address:**
   - **Criteria for recipient selection (to include diagnoses, age)**
   - **Criteria for donor selection (to include eligible match grade)**
   - **Requirements for financial approval**
   - **Procedures for recipient evaluations**
   - **Procedures for administration of the preparative regimen**
   - **Procedures for the prevention and treatment of graft-versus host disease**
   - **Procedures for post-transplantation care**

This application has been submitted by: ____________________ **Date:** ____________________
(Print the name)
____________________ **Title:** ____________________
(Signature)

Questions and/or completed applications with appropriate attachments should be sent to:

Margret Su
Operating Officer
Buddhist Tzu Chi Stem Cells Center
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Phone: 886-8561825 ext. 13142
Fax: 886-8574324
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