Center of Excellence Program

Application Form

Testicular Cancer Awareness Foundation is a nonprofit organization that strives to spread awareness, support the fight against testicular cancer and continue to save lives. We appreciate your interest in the ***Testicular Cancer Awareness Foundations Centers of Excellence Program***; your participation will ensure we achieve this mission.

TCAF works tirelessly to improve early detection of testicular cancer through education programs, outreach and awareness programs, disbursing medical brochures, shower cards and widespread social media presence. Testicular cancer is a relatively rare disease and outcomes are related to the volume and expertise of care. Approximately 10,000 new cases are diagnosed each year in the United States alone. The designation of the Center of Excellence Program facilitates getting men consistent, reliable and expert care for the treatment of testicular cancer. It is our goal that this program serves as a resource for testicular cancer patients and will be made available online through our website and social media to our vast patient network.

It is the goal of our Center of Excellence Program to be inclusive – the more centers with testicular cancer expertise the better! However, the program will consist of centers that demonstrate expertise in the treatment of testicular cancer. All applications are reviewed by TCAF and our Medical Advisory Team. Acceptance into the program is dependent on meeting TCAF's Center of Excellence criteria, professional reputation, patient feedback and commitment to the disease. Individuals who demonstrate expertise but do not meet the criteria as a center will be designated as a TCAF Individual of Excellence.

In applying to be a Testicular Cancer Awareness Foundation Center of Excellence, please provide as much of the following as possible and return by mail or electronic format to:

Testicular Cancer Awareness Foundation
202 North Avenue #305
Grand Junction, CO 81501
Email: info@testescancer.org

TESTICULAR CANCER CENTER OF EXCELLENCE REQUISITES

1. A team of multi-disciplinary practitioners with an interest and expertise in TC. The team must include at least one designated member from:
   - **Urology** (Urologic Oncology preferred)
   - **Medical Oncology**
   - **Radiation Oncology**
   - Additional team members are not required but may include: vascular, general, thoracic or head and neck surgery, fertility, endocrinology, pathology, and/or radiology.

2. An interest and infrastructure in research.
   - This may include clinical, translational or basic science research.
   - An emphasis will be placed on institutions with recent and impactful publications.

3. A survivorship infrastructure must be established and offered to patients, and could include;
   - Cancer surveillance strategy
   - Monitoring for treatment-related toxicity
   - Family planning/fertility
   - Social networks and advocacy

   Survivorship does not have to originate from the institution. TCAF has a national survivorship plan that may be given to patients if the center does not have a survivorship plan.

4. Each center must see at least 25 patients per year with TC. *This criterion is flexible with justification.*

CENTER OF EXCELLENCE AND MULTIDISCIPLINARY TEAM INFORMATION

I. INSTITUTION

NAME OF INSTUTITION: _____

POSTAL MAILING ADDRESS: _____

MAIN TELEPHONE NUMBER: _____

WEBSITE: _____

II. LEAD CLINICIAN: For TCCOE identification purposes.

LEAD CLINICIAN: _____

LEAD CLINICIAN SPECIALTY: _____

POSTAL MAILING ADDRESS: _____

TELEPHONE: _____

EMAIL: _____

ASSISTANT: _____

ASSISTANT EMAIL: _____

III. POINT OF CONTACT: the person to be contacted by patients pursuing care at specific institution.

POC: _____

POC SPECIALTY: _____

POSTAL MAILING ADDRESS: _____

TELEPHONE: _____

EMAIL: _____

ASSISTANT: _____

ASSISTANT EMAIL: _____

IV. MULTIDISCIPLINARY TEAM: an asterisks (*) indicates required specialties. Please add members of the team as you see fit.

UROLOGY*

[ ] check here if lead clinician or point of contact

PHYSICIAN OR PRACTITIONER NAME: _____

POSTAL MAILING ADDRESS: _____

TELEPHONE: _____

EMAIL: _____

ASSISTANT: _____

ASSISTANT EMAIL: _____

MEDICAL ONCOLOGY*

[ ] check here if lead clinician or point of contact

PHYSICIAN OR PRACTITIONER NAME: _____

POSTAL MAILING ADDRESS: _____

TELEPHONE: _____

EMAIL: _____

ASSISTANT: _____

ASSISTANT EMAIL: _____

RADIATION ONCOLOGY*

[ ] check here if lead clinician or point of contact

PHYSICIAN OR PRACTITIONER NAME: _____

POSTAL MAILING ADDRESS: _____

TELEPHONE: _____

EMAIL: _____

ASSISTANT: _____

ASSISTANT EMAIL: _____

GENERAL SURGERY

PHYSICIAN OR PRACTITIONER NAME: _____

POSTAL MAILING ADDRESS: _____

TELEPHONE: _____

EMAIL: _____

ASSISTANT: _____

ASSISTANT EMAIL: _____

THORACIC SURGERY

PHYSICIAN OR PRACTITIONER NAME: _____

POSTAL MAILING ADDRESS: _____

TELEPHONE: _____

EMAIL: _____

ASSISTANT: _____

ASSISTANT EMAIL: _____

VASCULAR SURGERY

PHYSICIAN OR PRACTITIONER NAME: _____

POSTAL MAILING ADDRESS: _____

TELEPHONE: _____

EMAIL: _____

ASSISTANT: _____

ASSISTANT EMAIL: _____

HEAD AND NECK SURGERY

PHYSICIAN OR PRACTITIONER NAME:_____

POSTAL MAILING ADDRESS: _____

TELEPHONE: _____

EMAIL: _____

ASSISTANT: _____

ASSISTANT EMAIL: _____

FERTILITY/FAMILY PLANNING

PHYSICIAN OR PRACTITIONER NAME: _____

POSTAL MAILING ADDRESS: _____

TELEPHONE: _____

EMAIL: _____

ASSISTANT: _____

ASSISTANT EMAIL: _____

ENDOCRINOLOGY

PHYSICIAN OR PRACTITIONER NAME: _____

POSTAL MAILING ADDRESS: _____

TELEPHONE: _____

EMAIL: _____

ASSISTANT: _____

ASSISTANT EMAIL: _____

PATHOLOGY

PHYSICIAN OR PRACTITIONER NAME: _____

POSTAL MAILING ADDRESS: _____

TELEPHONE: _____

EMAIL: _____

ASSISTANT: _____

RADIOLOGY

PHYSICIAN OR PRACTITIONER NAME: _____

POSTAL MAILING ADDRESS: _____

TELEPHONE: _____

EMAIL: _____

ASSISTANT: _____

ASSISTANT EMAIL: _____

V. SERVICES PROVIDED ON SITE: please check all that apply

[ ] Laboratory Services

[ ] Ultrasound

[ ] CT Scanner

[ ] PET/CT Scanner

[ ] MRI Scanner

[ ] Fertility Evaluation

[ ] Hormonal Evaluation

[ ] Sperm Cryopreservation

[ ] Surgical Pathology

[ ] Orchiectomy

- [ ] Testis Sparing Surgery
- [ ] Testicular Prosthesis

[ ] Retroperitoneal Lymph Node Dissection

- [ ] Open RPLND
- [ ] Minimally-invasive RPLND
- [ ] Multidisciplinary RPLND

[ ] Radiation Therapy

[ ] Chemotherapy

[ ] Stem Cell Transplant

[ ] Intensive Care Unit

VI. PATIENT VOLUME

Please provide the approximate number of patients (a range is acceptable) per year at your institution,

Total Treated:

Undergoing Orchiectomy:

Receiving Chemotherapy:

Undergoing RPLND:

V. PATIENT APPOINTMENTS

Please provide the approximate time before a patient could get an appointment (a range is acceptable) at your institution.

_____
_____
_____

RESEARCH INFRASTRUCTURE AND INTERESTS

Please describe your institutions commitment to testicular cancer research. Research may include clinical, translational or basic science research.

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Please provide the most recent five publications from your institution or group regarding testicular cancer. A complete reference list can be added if desired.

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SURIVIVORSHIP

Testicular cancer enjoys one of the highest rates of cure for a solid organ malignancy. However, many men are subjected to surgery, chemotherapy and radiation therapy with lasting effects on health, fertility, hormonal function and general well-being. Survivorship may include: cancer surveillance strategy, monitoring for treatment-related toxicity, family planning/fertility, social networks and advocacy work. Survivorship does not have to originate from the institution, but the institution may have a relationship with a local or national survivorship program.

Please describe your institution's survivorship efforts, strategic partnerships and/or provide contact information for individuals involved in survivorship care.

CENTER OF EXCELLENCE STATEMENT

Why is your institution a Testicular Cancer Center of Excellence?

PATIENT REFERRALS

Please provide the name and contact of two to four patients who are willing to be contacted about the care they received at your institution.

NAME: _____

POSTAL MAILING ADDRESS: _____

TELEPHONE: _____

EMAIL: _____

PRIMARY PHYSICIAN: _____

NAME: _____

POSTAL MAILING ADDRESS: _____

TELEPHONE: _____

EMAIL: _____

PRIMARY PHYSICIAN: _____

NAME: _____

POSTAL MAILING ADDRESS: _____

TELEPHONE: _____

EMAIL: _____

PRIMARY PHYSICIAN: _____

NAME: _____

POSTAL MAILING ADDRESS: _____

TELEPHONE: _____

EMAIL: _____

PRIMARY PHYSICIAN: _____