



COMMISSION ON ACCREDITATION FOR RESPIRATORY CARE
CHANGE IN MEDICAL DIRECTOR/CO-MEDICAL DIRECTOR
Entry into RC Practice (ENTRY)

CHANGE IN KEY PROGRAM PERSONNEL (ENTRY)

MEDICAL DIRECTOR STATUS

- Medical Director Co-Medical Director
 Permanent Temporary Acting
 *Explanation of status is located in Accreditation Policies 6.0-Personnel

Program Name:

Program Number:

FORMER MEDICAL DIRECTOR/CO-MEDICAL DIRECTOR

Name: _____ **Credentials:** _____
Reason for Change: Retiring Resigning Reassignment Other (reason)

NEW MEDICAL DIRECTOR/CO-MEDICAL DIRECTOR

Name: _____ **Credentials:** _____

Same person as the base program or ADT? Yes No Not applicable

Address:

City: _____ **State:** _____ **ZIP Code:** _____

Work #: _____ **Cell #:** _____ **E-mail:** _____

State License Number: _____ **Expires:** _____

PLEASE NOTE: The MD must be a licensed physician and Board certified as recognized by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) in a specialty relevant to respiratory care. **{Standard 2.11}**
 *Further Explanation is located on Accreditation Policies 6.0-Personnel

PREPARER CHECKLIST...

- | | |
|---|---|
| <input type="checkbox"/> Letter of Appointment/Acceptance | Send all 5 completed documents to:
CoARC
Shelley Christensen
shelley@coarc.com |
| <input type="checkbox"/> Curriculum Vitae | |
| <input type="checkbox"/> Copy of State License with expiration date | |
| <input type="checkbox"/> Copy of Board Certification(s) with exp. date(s) | |
| <input type="checkbox"/> This completed form | |

FOR COARC EXECUTIVE OFFICE ONLY

<input type="checkbox"/> Approved	<input type="checkbox"/> Confirmation of Change Sent to Program
<input type="checkbox"/> Not Approved	<input type="checkbox"/> Updated Database
<input type="checkbox"/> Temporary until ____/____/____	
Signature: _____	Signature: _____
Date: ____/____/____	Date: ____/____/____