



COMMISSION ON ACCREDITATION FOR RESPIRATORY CARE
Clinical Site Affirmation Form

Program Number:

Program Name and location:

A Clinical Site Affirmation Form is required for the following CoARC Accreditation Policies:

New Programs Policy 2.02/ 2.03/ 2.05/ 2.06

Existing Programs Policy 9.10

Visit the CoARC website at www.coarc.com for a copy of the Accreditation Policies and Procedures Manual.

The sponsor of the program must complete only Questions 1 through 4 for each clinical site. The Respiratory Care Department Director must complete the Statement of Support and submit the entire form directly to the CoARC Executive Office. Submitting incomplete or incorrect forms may result in delay or denial of the Approval of Intent or substantive change. Completed copies of this form submitted by the sponsor will not be accepted.

1. a. Clinical Site Name (NO healthcare system names):

City:

State:

b. One-way distance, in miles, of this site from the main base program: miles

2. Content areas provided by this clinical site. Check all that apply.

Adult floor: [] Adult ICU: [] Pediatric floor: [] Pediatric ICU: []

Neonatal ICU: [] Intubation: [] Home Care: [] Long-term care: []

Rehab: [] Sleep: [] ER: [] ABG: [] EKG: [] PFT: []

Other (specify):

3. Student Capacity

Number of students per cohort to be assigned to this clinical site at one time:

First-year: Second-year: Total cohorts per year:

4. Clinical site representative serving on Study Group, or Advisory Committee.

Name and credentials:

Title:

Email:

If the representative from this clinical site is not on the new program's Study Group or the existing program's Advisory Committee, then briefly explain the reason.



(This section to be completed by the clinical site ONLY)

1. Anticipated student/clinical faculty supervision ratio at this site:
2. Identify any other respiratory therapy programs at this site concurrently. If additional space is needed, please provide the information separately.

Name of Program(s)	Number of Students
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Statement of Support

We at _____ (facility name) affirm that we have sufficient clinical resources to support our share of the clinical activities required of the respiratory care program from (sponsoring institution name) _____. With this signed affirmation, we agree to host up to _____ first-year students per cohort and _____ second-year students per cohort from this sponsor with a maximum of _____ cohort from this sponsor. Additionally, we affirm that conducting clinical activities with students from _____ will not compromise the quality of clinical education experiences for existing affiliated programs.

Respiratory Care Dept. Director's

Name:
 Email:
 Office #:
 Signature:

 Date:

Facility Administrator's
(above the RC department)

Name:
 Email:
 Office #:
 Signature:

 Date:

THE CLINICAL SITE COMPLETING THIS FORM MUST EMAIL OR FAX THE ENTIRE DOCUMENT TO THE COARC EXECUTIVE OFFICE:

Commission on Accreditation for Respiratory Care
shelley@coarc.com
 Fax (817) 354-8519

For questions concerning this form, please contact Shelley Christensen at (817) 283-2835
 ext. 106