COMMISSION ON ACCREDITATION FOR RESPIRATORY CARE

Clinical Site Affirmation Form – Sleep Disorders Specialist (SDS) Program Option

Proposed Program Name and Location:

A Clinical Site Affirmation Form is required for **CoARC Accreditation Policy 2.04**

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

The sponsor of the proposed program must complete **only Questions 1 through 4 for each clinical site.** The Respiratory Care/Sleep Center Department Director must complete the Statement of Support and submit the entire form directly to the CoARC Executive Office. **Submitting an incomplete or incorrect form may result in a delay or denial of the Approval of Intent to start a new program. 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.**

   SDS Adult: ☐ SDS Peds: ☐ PAP: ☐ MSLT/MWT: ☐
   Protocols: ☐ Scoring: ☐ Compliance: ☐ Portable/HST: ☐
   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. Lab/Center Accreditation Status:

5. 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.

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(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

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.

RC Dept./Sleep Center Director's

Name:
Email:
Office #:
Signature:

Date:

Facility Administrator's

Name:
Email:
Office #:
Signature:

Date:

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

bonnie@coarc.com

Commission on Accreditation for Respiratory Care
264 Precision Blvd, Telford, TN 37690

For questions concerning this form, please contact Bonnie Marrs at (817) 283-2835 ext. 102