



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
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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.

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 MAIL OR FAX THE ENTIRE DOCUMENT TO THE COARC EXECUTIVE OFFICE:

Commission on Accreditation for Respiratory Care
 1248 Harwood Road
 Bedford, TX 76021
 Fax (817) 510-1063

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