COMMISSION ON ACCREDITATION FOR RESPIRATORY CARE

Clinical Site Affirmation Form

Program Number:

Program Name and location:

A Clinical Site Affirmation Form is required for new programs (CoARC Policy 2.0) and existing programs with substantive changes (CoARC Policy 9.0). Visit the CoARC website at www.coarc.com for a copy of the Accreditation Policies and Procedures Manual.

The program sponsor must complete **only Questions 1 through 4 for each clinical site.** The Respiratory Care Department Director and Facility Administrator must complete the Statement of Support and submit the entire form directly to the CoARC Executive Office. The clinical site is allowed to share the completed form with the program. **Submitting incomplete or incorrect forms may result in delay or denial of the Approval of Intent or substantive change. This form submitted by the program sponsor will <u>not</u> be accepted.**

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

City: State:

Total Number of beds: ____

Number of Adult ICU beds: ____

Number of Ped ICU beds: ____

Number of NICU beds: ____

b. One-way distance, in miles, of this site from the 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 (this must match the program sponsor's clinical schedule)

Total number of students to be assigned to this clinical site:

First-year: Second-year: Total students per calendar year:

Total number of students per shift assigned to this clinical site:

First-year: Second 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 care programs at this site concurrently. If additional space is needed, please provide the information separately.

Name of Program(s)	Number of Students at Site

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 (program sponsor's name): _____. With this signed affirmation, we agree to host up to _____ first-year students per calendar year and _____ second-year students per calendar year from this sponsor. Additionally, we affirm that conducting clinical activities with students from (program sponsor's name): _____ will not compromise the quality of clinical education experiences for existing affiliated programs.

Respiratory Care Dept. Director

Name: _____
Email: _____
Office #: _____
Signature: _____
Date: _____

Facility Administrator
(above the RC department)

Name: _____
Email: _____
Office #: _____
Signature: _____
Date: _____

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

Commission on Accreditation for Respiratory Care
erica@coarc.com

For questions concerning this form, please contact Erica Reed at (817) 283-2835 ext. 108