COMMISSION ON ACCREDITATION FOR RESPIRATORY CARE

Frequently Asked Questions

Section 2: Institutional Resources and Personnel Resources

Guidance for CoARC-accredited programs, sponsoring institutions, healthcare employers, and consortium partners

Based on the CoARC 2027 Entry into Practice Standards and the supplied apprenticeship planning documents

Commission on Accreditation for Respiratory Care
Effective date of cited Standards: January 1, 2027

Purpose. This FAQ explains common implementation questions related to Section 2. It should be read together with the Standards, Interpretive Guidelines, Evidence of Compliance, and applicable CoARC policies and procedures.

At a glance

- Standard 2.01 — Institutional Resources
- Standard 2.02 — Key Program Personnel
- Standards 2.03–2.06 — Program Director
- Standards 2.07–2.10 — Director of Clinical Education
- Standard 2.11 — Medical Director
- Standards 2.12–2.13 — Optional Program Personnel
- Standard 2.14 — Instructional Capacity and Supervision
- Standards 2.15–2.17 — Support, Advisory Committee, and Resource Assessment

Standard 2.01 — Institutional Resources

1. What resources must the sponsor provide?

The sponsor must provide sufficient fiscal, academic, and physical resources to achieve program goals at every instructional location and through every instructional methodology. Resources must support current enrollment, program sustainability, innovation, and, if necessary, teach-out obligations.

2. Must students have access to laboratories outside scheduled class time?

Programs must have a reasonable mechanism for equitable student access to program laboratories, including OCLS locations, outside designated curriculum times and with appropriate supervision.

3. What is required before enrolling a distance-education student?

Arrangements for all necessary laboratory and clinical instruction must be completed before the student enrolls and maintained throughout matriculation. Resources available through distance delivery must be equivalent to those at the base location.

Standard 2.02 — Key Program Personnel

4. Which Key Personnel are always required?

Every program must appoint one full-time PD, one full-time DCE, and a Medical Director. A sleep specialist option also requires a Primary Sleep Specialist Instructor; each satellite requires a Satellite Site Coordinator; and each geographically separate ADT location requires an ADT Coordinator.

5. May PD or DCE duties be divided among several individuals?

No. Clear authority and accountability are required, so only one individual may serve in each role. The PD and DCE must each hold a full-time appointment, as defined by the sponsor, of sufficient length to fulfill the role.

6. What appointment documentation is required?

Maintain current Letters of Appointment and Acceptance, job descriptions with clearly assigned responsibilities and evidence of periodic review, academic appointments and privileges, and an organizational chart showing reporting relationships. Current Key Personnel and faculty must also be listed on the program website.

Standards 2.03–2.06 — Program Director

7. What is the PD's central role?

The PD is the program's academic and administrative leader and CoARC's primary official contact. The PD coordinates accreditation communications, program planning and assessment, fiscal management, curriculum oversight, and collaboration with the DCE.

8. How much administrative release time must the PD receive?

The PD must receive a formal, documented reduction of at least 25% from the sponsor's standard full-time workload in teaching, research, service, or an equivalent workload area. The reduction must provide time for the full scope of program administrative and accreditation responsibilities.

9. Do stipends or teaching preparation count toward the PD's 25% release?

No. Stipends and teaching-related activities, including didactic, laboratory, or simulation setup, do not constitute a release of workload. Compliance requires a documented workload reduction.

10. What degree must the PD hold?

For an associate-degree program, at least a baccalaureate degree is required. For a program awarding a bachelor's or master's degree, at least a master's degree is required. The degree may be in any field but must be from an appropriately accredited institution; foreign degrees require an acceptable equivalency evaluation.

11. What professional qualifications must the PD possess?

The PD must hold a valid RRT credential and a current, applicable license; have at least 4 years of RRT experience, including 2 years in clinical respiratory care; have 2 years of qualifying teaching experience; and complete the CoARC Key Personnel Training Program when required.

12. When must a newly appointed permanent PD complete the PD/DCE Academy?

When required, within 24 months of permanent appointment. Prior qualifying service and prior completion may satisfy the requirement as described in the Interpretive Guideline. Acting or temporary appointees are not required to complete the Academy during the interim appointment.

13. May the PD work remotely?

Yes, if the sponsor provides on-site personnel for duties the PD cannot perform remotely, immediate access to necessary data and technology, and advance disclosure of the arrangement to prospective students. The PD must remain accessible and maintain frequent, consistent contact across all locations.

Standards 2.07–2.10 — Director of Clinical Education

14. What is the DCE responsible for?

The DCE leads the development, administration, evaluation, and continuous improvement of clinical education; coordinates sites and supervision; documents clinical activities; and works with the PD to align clinical experiences with didactic and laboratory education.

15. How much administrative release time must the DCE receive?

The DCE must receive a formal, documented reduction of at least 25% from the sponsor's standard full-time workload. Stipends and teaching-related duties do not count as release time.

16. What degree and experience must the DCE have?

Degree requirements mirror those for the PD: a baccalaureate degree for an associate-degree program and a master's degree for a bachelor's- or master's-degree program. The DCE must also hold a valid RRT credential and applicable license, have four years of RRT experience including two clinical years, two years of qualifying teaching experience, and complete required Key Personnel training.

17. Must the DCE be present at every clinical site?

No. The DCE may use qualified clinical instructors and preceptors, but retains responsibility for oversight, communication, supervision verification, evaluation consistency, and clinical-program effectiveness at every location.

Standard 2.11 — Medical Director

18. What qualifications must the Medical Director have?

The MD must be a currently licensed physician who is Board-certified by an ABMS or AOA member board in a specialty relevant to respiratory care, such as pulmonary, critical care, anesthesiology, sleep medicine, neonatology, or another closely related specialty.

19. What level of MD involvement is expected?

Involvement must be ongoing and substantive. The MD provides medical guidance, helps keep didactic, laboratory, and clinical instruction aligned with current practice, collaborates with the PD and DCE, and facilitates structured, recurring physician interaction with students.

20. Does attendance at the Advisory Committee meeting satisfy the MD's responsibilities?

No. Advisory Committee participation is required documentation but does not substitute for medical guidance, curriculum involvement, collaboration, or facilitation of physician-student interaction.

Standards 2.12–2.13 — Optional Program Personnel

21. What qualifications are required for the Primary Sleep Specialist Instructor?

The instructor must hold a current CRT-SDS, RRT-SDS, or RPSGT credential; at least an associate degree; at least 3 years of clinical sleep-technology experience; and at least 1 year of teaching experience.

22. What qualifications are required for a satellite or geographically separate ADT coordinator?

The coordinator must be a current RRT, hold at least a bachelor's degree, and serve as Key Personnel with responsibility for equivalency at the location and ongoing communication with the PD and DCE.

23. How can a program demonstrate equivalency at a satellite or ADT location?

Use consistent syllabi and materials, comparable learning and clinical assignments, competency and assessment data, access to support services, communication records, and documented oversight showing comparable outcomes.

Standard 2.14 — Instructional Capacity and Supervision

24. What are the maximum student-to-instructor ratios?

Laboratory: 12:1. Clinical instructor: 6:1. Clinical preceptor: 2:1. Simulation used as a substitute for clinical experience: 6:1. A site may require lower ratios.

25. When does the 12:1 laboratory ratio apply?

It applies whenever students are engaged in hands-on skill instruction, supervised practice, competency checkoffs, or other performance activities, regardless of how the course period is labeled. A lecture during scheduled laboratory time is didactic only if no hands-on activity or evaluation occurs simultaneously.

26. Who may evaluate students in clinical settings?

Qualified clinical instructors and site-employed clinical preceptors may participate. The program must orient and train evaluators in their roles, program policies, checkoffs, and evaluation tools and must promote consistent evaluation practices.

27. May instructors come from disciplines outside respiratory care?

Yes. Physicians, pharmacists, nurses, pulmonary function technologists, and others may teach content for which they possess appropriate education, specialized training, experience, and competence. Volunteer, adjunct, part-time, and full-time instructors may qualify.

Standards 2.15–2.17 — Support, Advisory Committee, and Resource Assessment

28. May administrative or clerical support be shared with other programs?

Yes. Shared or pooled staff are acceptable if the level and type of support are sufficient for the program's size, delivery method, workload, and complexity, and allow Key Personnel to meet their responsibilities.

29. Who must be represented on the Advisory Committee?

At minimum: students, graduates, faculty, college administration, employers, physicians, clinical affiliates, and the public. The committee must meet with Key Personnel at least annually.

30. Who may chair the Advisory Committee?

The members must elect the Chair. Sponsor employees and program Key Personnel may not serve as Chair. The PD and DCE should participate as non-voting members.

31. Who qualifies as the public member?

The public member must have no direct relationship with the program or sponsor and may not be a current or former member of any healthcare profession.

32. How long must Advisory Committee records be retained?

Maintain written policies, membership records, deliberations, and meeting minutes for at least five years.

33. How often must resources be assessed?

At least annually using the CoARC Student and Personnel Program Resource Surveys, with results documented in the RAM and submitted with the RCS. Each program and program option must be assessed separately and identified using the applicable program CoARC ID.

34. What benchmark indicates acceptable resource performance?

CoARC considers at least 80% of responses rated 3 or higher in each resource area acceptable. A deficient or suboptimal area requires analysis, a written action plan, documented implementation, and subsequent evaluation of effectiveness.

Reference

Primary source: CoARC 2027 Accreditation Standards for Entry into Respiratory Care Professional Practice, Section 2 — Institutional Resources and Personnel Resources, approved March 2026. Current CoARC policies, procedures, forms, thresholds, and deadlines should also be consulted when applicable.