

**APPLICATION FOR CONTINUING ACCREDITATION OF AN EDUCATIONAL  
PROGRAM IN MEDICAL DOSIMETRY  
FORM 100C-MD**

**Sponsoring Institution:** \_\_\_\_\_ **Program #** \_\_\_\_\_

**This application must be completed by all programs applying for continuing accreditation and must be submitted with the self-study report.**

- The signatures of sponsoring institution/program officials constitute a request for initiation of the accreditation process.
- Required Program Official Documents:
  - **For all currently recognized program officials** (program director and educational coordinator), the program must only submit documentation of **current** MDCB registration and (if applicable) ARRT registration or unrestricted state license or equivalent. For clinical preceptor(s), **current** MDCB registration.
  - For program officials not currently recognized, submit **Form 102MD**, a **current** curriculum vitae, documentation of **current** MDCB and (if applicable) ARRT registration or unrestricted state license must be provided for the program director and educational coordinator. Documentation of the appropriate degree attainment from an academic institution accredited by an agency recognized by the United States Department of Education or the Council for Higher Education Accreditation must be provided for the program director and educational coordinator. (**Standard Six - Objective 6.1**.)
  - Degree documentation, not previously provided, of baccalaureate degrees or higher from an academic institution accredited by an agency recognized by the United States Department of Education or the Council for Higher Education Accreditation, must be provided for inclusion in the program's database listing. (*Although not required for clinical preceptors, the JRCERT database will reflect degrees only upon submission of appropriate documentation. If degree documentation is not received for a clinical preceptor, it will be assumed that the program does not wish to have the degree noted.*)
- A **current** affiliation agreement with Affiliation Agreement Criteria sheet, see page 7 of the application (**Standard Three - Objective 3.2**), for each clinical practice setting.
- Documentation of **current** The Joint Commission (TJC) accreditation or equivalent for each clinical practice setting. For non-hospital clinical practice settings that are not accredited, documentation of compliance with state and/or federal radiation safety regulations may be used as equivalent (**Standard Two - Objective 2.8**).
- **One month prior** to the required date of submission, the program will receive a current database listing. The program must review the listing for accuracy, note any changes and mail with original application and self-study report to:

**JRCERT**  
**20 N. Wacker Drive**  
**Suite 2850**  
**Chicago, IL 60606-3182**
- Programs are responsible for providing a hard copy of the application and self-study report directly to each member of the site visit team
- The **appropriate fee** - an invoice for the application fee will be provided by the JRCERT upon receipt and review of the application and self-study report.

**I. SPONSORING INSTITUTION:**

**Institution Type: (Check one)**

- 4-year College or University
- Community College
- Technical College or Institute

- Hospital
- Military/Government

- Consortium
- Proprietary

**The signatures of sponsoring institution/program officials constitute a request for initiation of the accreditation process.**

**Chief Executive Officer of Sponsoring Institution:**

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|              |                    |       |
|--------------|--------------------|-------|
| Name (Print) | Degree/Credentials | Title |
|--------------|--------------------|-------|

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Signature

***One month prior to the required date of submission, the program will receive a current database listing. The program must review the listing for accuracy.***

**Has the contact information for the CEO changed from that listed on the database?**

- no (If no changes, continue with Dean or Comparable Administrator Section.)
- yes (Provide updated information in the appropriate spaces below.)

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Mailing Address

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|      |       |          |
|------|-------|----------|
| City | State | Zip Code |
|------|-------|----------|

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E-mail address

**Dean or Comparable Administrator (Radiation Oncology Administrator for hospital-based programs):**

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|              |                    |       |
|--------------|--------------------|-------|
| Name (Print) | Degree/Credentials | Title |
|--------------|--------------------|-------|

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Signature

**Has the contact information for the Dean or Comparable Administrator changed from that listed on the database?**

- no (If no changes, continue with Program Information Section.)
- yes (Provide updated information in the appropriate spaces below.)

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Mailing Address

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|      |       |          |
|------|-------|----------|
| City | State | Zip Code |
|------|-------|----------|

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E-mail address

## II. PROGRAM INFORMATION:

Mailing Address: \_\_\_\_\_

(If different from sponsor)

City

State

Zip Code

A. Resident tuition per academic year: \$ \_\_\_\_\_

B. Award Granted:  Certificate  Degree(s) Specify type(s): \_\_\_\_\_

C. Length of program: \_\_\_\_\_ months

D. Number of students enrolled per class: \_\_\_\_\_ Number of cohorts enrolled per year: \_\_\_\_\_

E. Does the program have a Web page?

No

Yes

Web address: \_\_\_\_\_

F. Alternative learning options:

a. Are more than four medical dosimetry courses in the program curriculum offered via distance or hybrid delivery? \*  
**(NOTE: This does not include general education or pre-requisite courses.)**

No

Yes (If yes, please provide a narrative in Standard Four, Objective 4.4 that identifies the courses and describes the method of distance/hybrid delivery.)

b. Does the program offer any of the following curricular tracks? \*

No

Yes (**Check all that apply**)  Evening  Weekend  Part-time

G. Does the program have an articulation agreement with a postsecondary institution?

No

Yes

Name of institution \_\_\_\_\_

Credit applied toward  Associate degree  Baccalaureate degree

Name of institution \_\_\_\_\_

Credit applied toward  Associate degree  Baccalaureate degree

H. Hospital-based Programs ONLY:

NOTE: The JRCERT is responsible for oversight of Title IV funding for these programs only.

Are students of the program eligible for Title IV student financial aid such as Pell Grants, Work Study, Perkins Loans, Stafford Loans, Direct Loans, Plus Loans, and SEOG?

No

Yes

**\*Refer to Policy 10.800, Policy Statement 10.803**

**III. PROGRAM OFFICIALS:**

**Program Director:**

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Name (Print) Degree/Credentials

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Signature

**Has the contact information for the Program Director changed from that listed on the database?**

- no (If no changes, continue with Educational Coordinator Section.)**  
 **yes (Provide updated information in the appropriate spaces below.)**

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Mailing Address

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City State Zip Code

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Area Code and Business Phone Number Fax Number E-mail Address

**Educational Coordinator (if applicable):** Required if the program director is not credentialed in medical dosimetry or if the program has more than four (4) clinical practice settings or more than ten (10) students enrolled in the clinical component.

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Name (Print) Degree/Credentials E-mail Address

**Physics Advisor (if applicable):**

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Name (Print) Degree/Credentials E-mail Address

**IV. CLINICAL PRACTICE SETTINGS:**

A minimum of one clinical preceptor must be identified for each clinical practice setting. One full-time equivalent clinical preceptor is required for every five (5) students involved in the competency achievement process.

**List the requested clinical practice settings.**

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Name of Clinical Practice Setting

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Address

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Name of Clinical Preceptor(s)

**Maximum number of students program may assign to this site at any one time: \_\_\_\_\_**

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Name of Clinical Practice Setting

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Address

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Name of Clinical Preceptor(s)

**Maximum number of students program may assign to this site at any one time: \_\_\_\_\_**

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Name of Clinical Practice Setting

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Address

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Name of Clinical Preceptor(s)

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Name of Clinical Practice Setting

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Address

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Name of Clinical Practice Setting

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Address

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Name of Clinical Preceptor(s)

**Maximum number of students program may assign to this site at any one time: \_\_\_\_\_**

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Name of Clinical Practice Setting

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Address

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Name of Clinical Preceptor(s)

**Maximum number of students program may assign to this site at any one time: \_\_\_\_\_**

\_\_\_\_\_  
Name of Clinical Practice Setting

\_\_\_\_\_  
Address

\_\_\_\_\_  
Name of Clinical Preceptor(s)

**Maximum number of students program may assign to this site at any one time: \_\_\_\_\_**

\_\_\_\_\_  
Name of Clinical Practice Setting

\_\_\_\_\_  
Address

\_\_\_\_\_  
Name of Clinical Preceptor(s)

**Maximum number of students program may assign to this site at any one time: \_\_\_\_\_**

\_\_\_\_\_  
Name of Clinical Practice Setting

\_\_\_\_\_  
Address

\_\_\_\_\_  
Name of Clinical Preceptor(s)

**Maximum number of students program may assign to this site at any one time: \_\_\_\_\_**

\_\_\_\_\_  
Name of Clinical Practice Setting

\_\_\_\_\_  
Address

\_\_\_\_\_  
Name of Clinical Preceptor(s)

**Maximum number of students program may assign to this site at any one time: \_\_\_\_\_**

\_\_\_\_\_  
Name of Clinical Practice Setting

\_\_\_\_\_  
Address

\_\_\_\_\_  
Name of Clinical Preceptor(s)

**Maximum number of students program may assign to this site at any one time: \_\_\_\_\_**

(Make additional copies of this page as needed.)

**Program total capacity: \_\_\_\_\_  
(The maximum number of students program may have enrolled at any one time.)**

**V. AFFILIATION AGREEMENT CRITERIA:**

Attach a copy of this page to the front of each signed affiliation agreement submitted.

**Sponsoring Institution:** \_\_\_\_\_ **Program #** \_\_\_\_\_

**Clinical Practice Setting Name:** \_\_\_\_\_

The affiliation agreement must identify the following three (3) criteria as outlined below. Please identify where they are located in the document by highlighting, circling, or otherwise indicating the verbiage AND identifying the page and paragraph number for each.

**RESPONSIBILITY FOR STUDENT SUPERVISION:**

Page and Paragraph Number \_\_\_\_\_

**ADEQUATE NOTICE OF TERMINATION OF THE AGREEMENT:**

Page and Paragraph Number \_\_\_\_\_

The JRCERT considers three (3) months notice of termination or assurance that students currently enrolled will be provided the opportunity to complete the clinical component of the program as being appropriate.

**RESPONSIBILITY FOR LIABILITY:**

Page and Paragraph Number \_\_\_\_\_

NOTE: An affiliation agreement is not required for clinical practice settings owned by the sponsoring institution. In these instances; however, a memorandum of understanding is encouraged.