

**APPLICATION FOR CONTINUING ACCREDITATION OF AN EDUCATIONAL
PROGRAM IN RADIOGRAPHY
FORM 100C-R**

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, clinical coordinator(s), and clinical instructor(s)], the program must only submit documentation of **current** ARRT registration or equivalent.
 - For program officials not currently recognized, submit **Form 102R** with a **current** curriculum vitae and documentation of **current** ARRT registration or equivalent.
 - 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 instructors, the JRCERT database will reflect degrees only upon submission of appropriate documentation. If degree documentation is not received for a clinical instructor, 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 education setting.
- Documentation of **current** The Joint Commission (TJC) accreditation or equivalent for each clinical education setting. For non-hospital clinical education 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)

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> 4-year College or University | <input type="checkbox"/> Hospital | <input type="checkbox"/> Consortium |
| <input type="checkbox"/> Community College | <input type="checkbox"/> Military/Government | <input type="checkbox"/> Proprietary |
| <input type="checkbox"/> Technical College or Institute | | |

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

Chief Executive Officer of Sponsoring Institution:

Name (Print) Degree/Credentials Title

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.)

Mailing Address

City State Zip Code

E-mail address

Dean or Comparable Administrator (Radiology Administrator for hospital-based programs):

Name (Print) Degree/Credentials Title

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.)

Mailing Address

City State Zip Code

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 radiography 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:

Name (Print) Degree/Credentials

Signature

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

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

Mailing Address

City State Zip Code

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

Clinical Coordinator(s) (if applicable): Required if the program has more than five (5) clinical education settings or more than 30 students enrolled in the clinical component. The clinical coordinator position must be considered equal to a full-time equivalent but may be shared by no more than four (4) appointees.

Name (Print) Degree/Credentials E-mail Address

Name (Print) Degree/Credentials E-mail Address

Name (Print) Degree/Credentials E-mail Address

Name (Print) Degree/Credentials E-mail Address

IV. CLINICAL EDUCATION SETTINGS:

A minimum of one clinical instructor must be identified for each clinical education setting. One full-time equivalent clinical instructor is required for every ten (10) students involved in the competency achievement process.

List the requested clinical education settings.

Name of Clinical Education Setting

Address

Name of Clinical Instructor(s)

Maximum number of students program may assign to this site at any one time: _____

Name of Clinical Education Setting

Address

Name of Clinical Instructor(s)

Maximum number of students program may assign to this site at any one time: _____

Name of Clinical Education Setting

Address

Name of Clinical Instructor(s)

Maximum number of students program may assign to this site at any one time: _____

Name of Clinical Education Setting

Address

Name of Clinical Instructor(s)

Maximum number of students program may assign to this site at any one time: _____

Name of Clinical Education Setting

Address

Name of Clinical Instructor(s)

Maximum number of students program may assign to this site at any one time: _____

Name of Clinical Education Setting

Address

Name of Clinical Instructor(s)

Maximum number of students program may assign to this site at any one time: _____

Name of Clinical Education Setting

Address

Name of Clinical Instructor(s)

Maximum number of students program may assign to this site at any one time: _____

Name of Clinical Education Setting

Address

Name of Clinical Instructor(s)

Maximum number of students program may assign to this site at any one time: _____

Name of Clinical Education Setting

Address

Name of Clinical Instructor(s)

Maximum number of students program may assign to this site at any one time: _____

Name of Clinical Education Setting

Address

Name of Clinical Instructor(s)

Maximum number of students program may assign to this site at any one time: _____

Name of Clinical Education Setting

Address

Name of Clinical Instructor(s)

Maximum number of students program may assign to this site at any one time: _____

Name of Clinical Education Setting

Address

Name of Clinical Instructor(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 Education 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 education settings owned by the sponsoring institution. In these instances; however, a memorandum of understanding is encouraged.