**Clinical Postgraduate Applicant Program Information Form**

For institutions considering seeking provisional accreditation for clinical postgraduate physician assistant program.

*(Enter requested information by clicking on red text fields. Select from dropdown list by clicking on red text fields labeled “Select…” then clicking the arrow on the right.)*

|  |  |  |
| --- | --- | --- |
| **Sponsoring Institution:** | **Location of Institution:** | **Location of Program:** |
| Institution Name | City, State | City, State |
| **Name of Program:** | **Clinical Specialty Discipline** | **Length of Program:** |
| Name of Program | Clinical Specialty | Length in Months |

**Number of students requested for maximum class size:** Number of students

**Number of entering cohorts per year:** Number of cohorts

**Individual Responsible for Program Development:** (who will receive ARC-PA correspondence):

Name and **Credentials**

Institutional Title

Address 1

Address 2

City, State and Zip

Email

Phone

***\*\*PLEASE NOTE that the ARC-PA will not consider a consultant as the individual responsible for the development of the PA program.*** *If there is a change in the individual responsible for program development at any time during the provisional accreditation process, inform the ARC-PA immediately.\*\**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please complete the following:

I have read the ***Clinical Postgraduate Accreditation* *Standards*** (3rd edition, published 11/2019) (<http://www.arc-pa.org/wp-content/uploads/2020/11/Postgrad-Standards-3rd-ed_FINAL7.20.pdf>) with **attention to the Eligibility Section and Section D.** Select yes/no

I understand that attendance at an ARC-PA Clinical Postgraduate Provisional Conference (<http://www.arc-pa.org/postgraduate-accreditation/>) is strongly encouraged. Select yes/no

I attended a Postgraduate Provisional Conference in Select year

**Our institution meets the following criteria:**

1. Our clinical postgraduate PA program is established in a: (check all that apply)

school of allopathic or osteopathic medicine

college/university affiliated with appropriate clinical teaching facilities

medical education facility of the federal government

hospital, medical center or ambulatory clinic

other: Describe

1. The sponsoring institution is accredited by, and in good standing with: (check all that apply)

a recognized Regional[[1]](#footnote-2) or specialized and professional accrediting agency.

Name of Accrediting Agency: Select an agency

the Accreditation Association for Ambulatory Health Care (AAAHC),

the Commission on Accreditation of Rehabilitative Facilities (CARF) or,

the Joint Commission as a hospital/medical center or ambulatory clinic.

1. The clinical postgraduate program is operational with at least one enrolled PA trainee at the time of application for accreditation. Select yes/no
2. The clinical postgraduate PA program is to be offered by, or located within, an institution chartered by and physically located within the United States and where PA trainees are to be geographically located within the United States for their education. Select yes/no
3. The appropriate senior institutional official or governance board has granted approval to pursue the development and accreditation for the establishment of a clinical postgraduate PA program. Select yes/no
4. The clinical postgraduate PA program has been developed with a strong focus on clinical education in a recognized clinical specialty discipline. Select yes/no

The program requests placement on the Select an agenda (first choice) or the Select an agenda (second choice) Postgraduate Sub-commission Agenda. Agenda replacement requests are subject to approval by the ARC-PA and are not guaranteed until the ARC-PA confirms. Please note the following when selecting the agenda:

1. The site visit component of the evaluation process must take place as follows:

February agenda:  between October 1 and November 30

June agenda: between February 1 and March 30

September agenda:  between May 1 and June 30

1. Application materials are due 3 months before the site visit.
2. Programs will be provided with observations from the site visit and will have the opportunity to respond to those observations. The response will be due to the ARC-PA within three weeks of receipt of the site visit report regardless of holiday or break schedules.

**Chief Administrative Officer of the Sponsoring Institution:** (to receive copies of accreditation correspondence)

\*\***Notify** the ARC-PA regarding any changes immediately via email to [accreditationservices@arc-pa.org](mailto:accreditationservices@arc-pa.org) \*\*

|  |
| --- |
| **Name prefix:** Choose an item  **First name:** Enter first name  **Middle name (or initial):** Enter middle name  **Last Name:** Enter last name    **Academic credentials:** Enter credentials  **Institution title:** Choose an item or enter new title  **Address:** Enter address  Enter city, Enter state Enter zip  **Phone #:** Enter phone #  **Fax #:** Enter fax #  **E-mail address:** Enter email address |

|  |  |
| --- | --- |
| **Program Director Reports To:**  \*\***Notify** the ARC-PA regarding any changes immediately via email to [accreditationservices@arc-pa.org](mailto:accreditationservices@arc-pa.org) \*\* | |
| **Name prefix:** Choose an item  **First name:** Enter first name  **Middle name (or initial):** Enter middle name  **Last Name:** Enter last name    **Academic credentials:** Enter credentials  **Institution title:** Choose an item or enter new title  **Address:** Enter address  Enter city, Enter state Enter zip  **Phone #:** Enter phone #  **Fax #:** Enter fax #  **E-mail address:** Enter email address |

**Program Director:**

A3.08 The program director *should* be a PA with requisite experience in the specialty of the program. If the program director is not a PA, then the program director *must* be a physician.

a) If the program director is a PA, s/he *must* hold current *NCCPA* certification and current licensure in the state in which the program exists (unless exempt under state or federal law.)

b) If the program director is a physician, s/he *must* hold current licensure as an allopathic or osteopathic physician in the state in which the program exists and *must* be certified by an *ABMS-* or *AOA*-approved specialty board. (unless exempt under state or federal law.)

\*\***Notify** the ARC-PA regarding any changes immediately via email to [accreditationservices@arc-pa.org](mailto:accreditationservices@arc-pa.org) \*\*

|  |
| --- |
| **Name prefix:** Choose an item  **First name:** Enter first name  **Middle name (or initial):** Enter middle name  **Last Name:** Enter last name    **Academic credentials:** Enter credentials  **Program title:** Enter title  **FTE% with program:** Enter %  **Address:** Enter address  Enter city, Enter state Enter zip  **Phone #:** Enter phone #  **Fax #:** Enter fax #  **E-mail address:** Enter email address |

**Medical Director(s):**

|  |
| --- |
| **Name prefix:** Choose an item  **First name:** Enter first name  **Middle name (or initial):** Enter middle name  **Last Name:** Enter last name    **Academic credentials:** Enter credentials  **Program title:** Enter title  **FTE% with program:** Enter %  **Address:** Enter address  Enter city, Enter state Enter zip |

|  |
| --- |
| **Name prefix:** Choose an item  **First name:** Enter first name  **Middle name (or initial):** Enter middle name  **Last Name:** Enter last name    **Academic credentials:** Enter credentials  **Program title:** Enter title  **FTE% with program:** Enter %  **Address:** Enter address  Enter city, Enter state Enter zip |

**Program Faculty:**

A3.01 *Program faculty* *must* include healthcare professionals who have the necessary education, specialty qualifications and expertise to provide didactic or clinical instruction and oversight for the *PA trainees.*

A3.04 The program *must* have a *sufficient* number of *program faculty* to provide *PA trainees* with the supervision, education and evaluation necessary to achieve advanced *competencies* safely.

Program faculty are defined as: Health care professionals assigned to work with the clinical postgraduate PA program as a major component of their work assignment.

|  |
| --- |
| **Name prefix:** Choose an item  **First name:** Enter first name  **Middle name (or initial):** Enter middle name  **Last Name:** Enter last name    **Academic credentials:** Enter credentials  **Program title:** Enter title  **FTE% with program:** Enter %  **Address:** Enter address  Enter city, Enter state Enter zip  **Phone #:** Enter phone #  **Fax #:** Enter fax #  **E-mail address:** Enter email address |

|  |
| --- |
| **Name prefix:** Choose an item  **First name:** Enter first name  **Middle name (or initial):** Enter middle name  **Last Name:** Enter last name    **Academic credentials:** Enter credentials  **Program title:** Enter title  **FTE% with program:** Enter %  **Address:** Enter address  Enter city, Enter state Enter zip  **Phone #:** Enter phone #  **Fax #:** Enter fax #  **E-mail address:** Enter email address |

|  |
| --- |
| **Name prefix:** Choose an item  **First name:** Enter first name  **Middle name (or initial):** Enter middle name  **Last Name:** Enter last name    **Academic credentials:** Enter credentials  **Program title:** Enter title  **FTE% with program:** Enter %  **Address:** Enter address  Enter city, Enter state Enter zip  **Phone #:** Enter phone #  **Fax #:** Enter fax #  **E-mail address:** Enter email address |

|  |
| --- |
| **Name prefix:** Choose an item  **First name:** Enter first name  **Middle name (or initial):** Enter middle name  **Last Name:** Enter last name    **Academic credentials:** Enter credentials  **Program title:** Enter title  **FTE% with program:** Enter %  **Address:** Enter address  Enter city, Enter state Enter zip  **Phone #:** Enter phone #  **Fax #:** Enter fax #  **E-mail address:** Enter email address |

**Administrative Support Staff:**

A2.03 The sponsoring institution *must* provide the program with the human resources to operate the educational program and to fulfill obligations to matriculating and enrolled PA trainees.

ANNOTATION: Human resources include the faculty and staff needed on a daily and ongoing basis, as well as those needed for specific program related activities. They include *sufficient* technical and *administrative support* staff to support faculty in accomplishing their assigned tasks.

|  |
| --- |
| **Name prefix:** Choose an item  **Name:** Enter name    **Program title:** Enter title  **Phone #:** Enter phone #  **E-mail address:** Enter email address  **FTE% with program:** Enter % |

|  |
| --- |
| **Name prefix:** Choose an item  **Name:** Enter name    **Program title:** Enter title  **Phone #:** Enter phone #  **E-mail address:** Enter email address  **FTE% with program:** Enter % |

|  |
| --- |
| **Name prefix:** Choose an item  **Name:** Enter name    **Program title:** Enter title  **Phone #:** Enter phone #  **E-mail address:** Enter email address  **FTE% with program:** Enter % |

**Other relevant Institutional or program data that you wish to include:**

Enter text

**Curriculum Sequence TEMPLATE**

**Complete** Part A and Part B

**PART A**

Present a schematic representation of the program components and their sequences in the horizontal spaces as appropriate using the template below.

|  |
| --- |
| **L** Lectures, seminars |
| **C** Case conferences/grand rounds |
| **R**  Clinical experiences (rotations) |
| **V** Vacation/Time off |

**Note:** Begin the table in the top row with the month your program begins. Be sure to add the month abbreviation. Place the curriculum categories that occur in the boxes for the months and years of the program. (See sample below).

| **SAMPLE Curriculum (program begins in July)** | | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| YR | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | June |
| ***1*** | ***L*** | ***L*** | ***L*** | ***L*** | ***C*** | ***C*** | ***C,R*** | ***L,C,R*** | ***R*** | ***R*** | ***R*** | ***R*** |
| ***2*** | ***R*** | ***V*** | ***C,R*** | ***L,C,E*** | ***C,R*** | ***R*** | ***R*** |  |  |  |  |  |
| ***3*** |  |  |  |  |  |  |  |  |  |  |  |  |

| **YOUR PROGRAM’S CURRICULUM** | | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| YR | Mth | Mth | Mth | Mth | Mth | Mth | Mth | Mth | Mth | Mth | Mth | Mth |
| ***1*** | Enter | Enter | Enter | Enter | Enter | Enter | Enter | Enter | Enter | Enter | Enter | Enter |
| ***2*** | Enter | Enter | Enter | Enter | Enter | Enter | Enter | Enter | Enter | Enter | Enter | Enter |
| ***3*** | Enter | Enter | Enter | Enter | Enter | Enter | Enter | Enter | Enter | Enter | Enter | Enter |

Comments: Click here to enter text

**PART B**

**Didactic Courses and Clinical Rotations**

List **all** required and elective **didactic courses or sessions and clinical experiences (rotations)**, listing required experiences before electives. For each, indicate the number of contact hours and indicate the instructional methods used.

| **Course, Rotation** |  | **Instructional Methods** | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Number of contact hours | Lectures / Seminars | Group discussions | Online coursework | Simulation | Clinical skills lab | Laboratory | Problem based learning | Self-instructional module | Program faculty site visit | Interaction with preceptors | Other: (Describe in comment below) |
| Enter text | # |  |  |  |  |  |  |  |  |  |  |  |
| Enter text | # |  |  |  |  |  |  |  |  |  |  |  |
| Enter text | # |  |  |  |  |  |  |  |  |  |  |  |
| Enter text | # |  |  |  |  |  |  |  |  |  |  |  |
| Enter text | # |  |  |  |  |  |  |  |  |  |  |  |
| Enter text | # |  |  |  |  |  |  |  |  |  |  |  |
| Enter text | # |  |  |  |  |  |  |  |  |  |  |  |
| Enter text | # |  |  |  |  |  |  |  |  |  |  |  |
| Enter text | # |  |  |  |  |  |  |  |  |  |  |  |
| Enter text | # |  |  |  |  |  |  |  |  |  |  |  |
| Enter text | # |  |  |  |  |  |  |  |  |  |  |  |
| Enter text | # |  |  |  |  |  |  |  |  |  |  |  |
| Enter text | # |  |  |  |  |  |  |  |  |  |  |  |
| Enter text | # |  |  |  |  |  |  |  |  |  |  |  |
| Enter text | # |  |  |  |  |  |  |  |  |  |  |  |
| Enter text | # |  |  |  |  |  |  |  |  |  |  |  |
| Enter text | # |  |  |  |  |  |  |  |  |  |  |  |
| Enter text | # |  |  |  |  |  |  |  |  |  |  |  |
| Enter text | # |  |  |  |  |  |  |  |  |  |  |  |
| Enter text | # |  |  |  |  |  |  |  |  |  |  |  |
| Enter text | # |  |  |  |  |  |  |  |  |  |  |  |
| Enter text | # |  |  |  |  |  |  |  |  |  |  |  |
| Enter text | # |  |  |  |  |  |  |  |  |  |  |  |
| Enter text | # |  |  |  |  |  |  |  |  |  |  |  |
| Enter text | # |  |  |  |  |  |  |  |  |  |  |  |

Comments: Enter text

I understand that the program will be subject to denial of accreditation and to denial of future eligibility for accreditation in the event that any of the statements or answers made in this document or the application are false or in the event that the program violates any of the rules or regulations governing applicant programs.

Form submitted by: Name

*The name entered above is deemed an electronic signature.*

Title: Title

Date: Date

Form completed by: Name

*If different than person submitting. The name entered above is deemed an electronic signature.*

Title: Title

Date: Date

**Submit this completed form, and a check payable to the ARC-PA for the Non-Refundable $2,000 Applicant Eligibility Fee via mail to:**

**ARC-PA, Inc.**

**Attn: Accreditation Services**

**3325 Paddocks Parkway, Suite 345**

**Suwanee, GA 30024**

**Institutions are required to submit the Eligibility Fee once. If the institution previously submitted the Fee for another postgraduate program,** Provide the name of the program here**, and do not submit another Fee.**

**You will receive a response within 15 business days of receipt of this form.**

1. |  |
   | --- |
   | Middle States Commission on Higher Education (MSCHE)  New England Commission of Higher Education (NECHE)  The Higher Learning Commission (HLC)  Northwest Commission on Colleges and Universities (NWCCU)  Southern Association of Colleges and Schools- Commission on Colleges (SACS)  Western Association of Schools and Colleges- Senior College and University Commission (WASC-ACSCU) |

   [↑](#footnote-ref-2)