**Clinical Postgraduate PA Applicant Program Information Form**

For institutions considering seeking initial 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 ORGANIZATION:**

Institution Name:

|  |
| --- |
| Enter Institution Name |

Location of Institution:

|  |
| --- |
| Enter City, State |

Chief Administrative Officer

* Name and Credentials: Enter Name and Credentials
* Institutional Title: Enter Institutional Title
* Address 1: Enter Address 1
* Address 2: Enter Address 2
* City, State and Zip code: Enter City, State and Zip
* Email: Enter Email Address
* Phone: Enter Phone Number

Organizational Structure

**Include** a copy of the Organizational Chart for the Sponsoring Organization and the Clinical Postgraduate Program (*must* clearly identify the reporting structure)

**CLINICAL POSTGRADAUTE PA PROGRAM INFORMATION:**

Official Program Name:

|  |
| --- |
| Enter Program Name |

Clinical Specialty Discipline(s):

|  |
| --- |
| Enter Clinical Specialty Discipline(s) |

Administrative Location Address:

|  |
| --- |
| Enter Address |

Anticipated program implementation date (if applicable): Select Date

Anticipated number of PA trainees (if applicable): Enter #

Residency Program Administration(s):

* Name and Credentials: Enter Name and Credentials
* Institutional Title: Enter Institutional Title
* Address 1: Enter Address 1
* Address 2: Enter Address 2
* City, State and Zip code: Enter City, State and Zip
* Email: Enter Email Address
* Phone: Enter Phone Number

Date Clinical Postgraduate PA Program first accepted trainees (if applicable): Select Date

Length of Clinical Postgraduate Program: Enter Program Length

PA trainee acceptance schedule (e.g., annual, quarterly, rolling): Enter PA trainee Schedule

Number of PA trainee cohorts accepted each year: Enter # PA

Current number of PA trainees: Enter # PA

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

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Please complete the following:

I have read the NP & PA Residency Program Accreditation Standards, (1st edition, published June 2023, Effective January 2024)Select yes/no

**The institution have met 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: If checked, Describe

1. Institutional Accreditation/Recognition

Clinical Postgraduate PA Program is established in a sponsoring organization that is recognized/accredited by: (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

Accreditation Association for Ambulatory Health Care (AAAHC)

American Osteopathic Association (AOA)

Commission on Accreditation of Rehabilitative Facilities (CARF)

DNV Healthcare

Healthcare Facilities Accreditation Program

Middle States Association of Colleges and Schools

New England Association of Schools and Colleges

North Central Association of Colleges and Schools

Northwest Association of Schools and Colleges

Southern Association of Colleges and Schools

Schools Western Association of Schools and Colleges

The Joint Commission

Higher Learning Commission (HLC)

Other, as approved by the governing boards for the ARC-PA

Date and Outcome of Last Accreditation/Recognition: Select Date

|  |
| --- |
| Enter Outcome |

(**Attach** a copy of most recent action)

1. The clinical postgraduate PA 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

Select an agenda (second choice)

Clinical 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.

**Program Educators:**

|  |
| --- |
| **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 #  **E-mail address:** Enter email address |

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| **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 #  **E-mail address:** Enter email address |

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| **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 #  **E-mail address:** Enter email address |

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| **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 #  **E-mail address:** Enter email address |

**Staff:**

|  |
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| **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 % |

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| **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 % |

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| **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**

**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 educators/site visit | Interaction with preceptors | Other: (Describe in comment below) |
| Enter text | # |  |  |  |  |  |  |  |  |  |  |  |
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Comments:

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| Enter text |

**STATEMENT AND SIGNATURES**

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: Enter Name

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

Title: Enter Title

Date: Select Date

Form completed by: Name

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

Title: Enter Title

Date: Select Date

**Submit this completed form, to:**

**ARC-PA, Inc.**

**Attn: Accreditation Services**

**3325 Paddocks Parkway, Suite 345**

**Suwanee, GA 30024**

[**AccreditationServices@arc-pa.org**](mailto:AccreditationServices@arc-pa.org)

For questions regarding Clinical Postgraduate Accreditation, please email [postgraduateaccreditation@arc-pa.org](mailto:postgraduateaccreditation@arc-pa.org)

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