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**JRC-DMS Request for 10-Year Accreditation**

This form is to be submitted with program’s self-study (if applicable). For details, see the 10-year accreditation policy located online in the JRC-DMS Policies and Procedures at [jrcdms.org/policies.htm](http://jrcdms.org/policies.htm).

**Date**:

**Institution**:

**Program**:

**Program Director**:

**Dean**:

Check the concentration(s) for which you are requesting 10-year accreditation:

General

Vascular

Cardiac

Pediatric Cardiac

1. **Dates of initial and last accreditation cycle for each learning concentration:**

|  |  |  |
| --- | --- | --- |
| **Concentration** | **Date of initial accreditation** | **Date of last continuing accreditation** |
| **General** |  |  |
| **Vascular** |  |  |
| **Cardiac** |  |  |
| **Pediatric Cardiac** |  |  |

1. **Names of key personnel:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Concentration** | **Initial accreditation** | **Last continuing accreditation** | **Current accreditation** |
| **Program Director** |  |  |  |
| **Clinical Education Coordinator** |  |  |  |
| **Concentration Coordinator** |  |  |  |
| **Medical Director** |  |  |  |
| **Other** |  |  |  |

1. **Has there been any change in program length since your last accreditation?**
2. **Has there been any change in clinical hours?**
3. **Please list your outcomes for the last annual report in the table below:**

|  |  |  |
| --- | --- | --- |
| **Outcome** | **JRC-DMS threshold** | **Program outcome** |
| Student Retention | 70% | % |
| Job placement rate | 75% | % |
| Return rate employer surveys | 50% | % |
| Return rate graduates surveys | 50% | % |
| Credentialing success | 60% | % |

Indicate if the following policies and procedures related to the DMS program will be affected by this change. If yes, provide explanation and any related documents.

|  |  |
| --- | --- |
| **Sponsorship** | Yes  No |
| **Number of learning concentrations** | Yes  No |
| **Support staff** | Yes  No |
| **Clinical site resources** | Yes  No |
| **Faculty** | Yes  No |
| **Medical advisor** | Yes  No |
| **Admissions procedures** | Yes  No |
| **Technical standards** | Yes  No |
| **Prerequisite GPA** | Yes  No |
| **Required number of clinical hours** | Yes  No |
| **Course assessment methods** | Yes  No |
| **Clinical assessment methods** | Yes  No |
| **Program assessment methods** | Yes  No |
| **Program budget** | Yes  No |
| **Library resources** | Yes  No |
| **Lab resources** | Yes  No |

Dean Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Program Director Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: