****

**Exception to Clinical Competency Request Form**

1. Which learning concentration are you requesting an exception for? Check one:
[ ]  General [ ]  Vascular [ ]  Cardiac [ ]  Pediatric Cardiac
2. Which standard are you requesting an exception for (i.e., III.C.7.g. Intracranial Cerebrovascular transcranial Doppler)?
3. In the space below, please provide a description of how your program will assess the hands-on skill of this competency (i.e., will students be required to practice this skill on faculty, fellow students, standardized patients, will they be required to master this skill at 80%, how will you measure their scanning skills of this competency?). If the program has a written policy that includes the previously described information, it may be attached.

|  |
| --- |
| Type Your Information Here: |
|       |

1. Please attach a copy of the form that you will use to assess this skill on the students.
2. Supply a letter from your clinical site(s) stating that this skill is not performed in their clinic/laboratory and that students do not have opportunity to perform this skill on patients at their facility.
3. Provide a letter from your Medical Advisor stating the exact verbiage below:­­

|  |
| --- |
| Date: \_\_\_\_\_\_\_\_\_I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Medical Advisor for the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ program, confirm that students enrolled in our program do not have access to these exams and verify that all documentation supported by the Program Director is accurate and complete. Sincerely, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Medical Advisor Name and Credentials\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Program Name and JRC-DMS # |