Digital Documents Available for Advance Review

The content below describes how a program should organize and make digital documents accessible to the evaluation team in advance of the visit. There are a variety of ways in which this can be done so each program should tailor the process to its resources and preferences. Consultation with IT or LMS support staff should occur at least six weeks prior to the site visit. The intent is for records to remain “with the program” for security reasons.

The program must create a digital record repository in its learning management system (LMS), within a secure web portal/page, or in a secure cloud. The records must be organized in labeled folders and files must have names that clearly indicate the content.

Format Examples:

- Create course called Site Visit in LMS, containing a folder for each section of the standards.
- In each folder, the program uploads the required records related to that particular standard.

- Create password protected webpage or online record portal for the site visit.
- Labeled folders contain the required records related to that particular standard.

- In a secure cloud storage area have folders labeled for each standard.
- Labeled folders contain the required records related to that particular standard.

Site evaluators must be given access (read-only) to the record repository a minimum of two weeks prior to the site visit.

Records available digitally:

- Evidence of faculty development for PD and CC for two years prior to the samples placed in the self-study. This may include transcripts, attendance certificates, meeting flyers, etc. Do not include items provided in the self-study. Provide only one piece of evidence per activity and make one folder of documents per person. (A2.3)

- Records of clinical affiliate visits by PD/CC for two years prior to those included in the self-study. Please arrange chronologically. (A3.2)

- List of books and journals related to nuclear medicine program, purchased within the most recent five years. (NM, ethics, pathology, healthcare administration, radiation physics, etc.) (B1e)

- Labeled folders for each course in the professional curriculum (C & D):
  - Didactic courses: syllabi, sample exam per course and a completed course project or two (if any). Projects include: student-created abstracts/articles, case study reports, capstone/senior theses, or photos of scientific posters.
  - Clinical course: syllabi, evaluation and competency forms not included in self-study.

- Program’s complete student handbook, if not included in the self-study. (Multiple standards)

- Certification exam report for 2022 graduates if not included in the self-study. (D3.1)

- Advisory committee minutes for two years prior to those provided in the self-study. (D3.3)
Documents Available for Review at the Site Visit
(These may be digital, hard copies or a mix of formats)

- Supporting documents collected and analyzed to complete Forms J and L for the past two academic years (likely 2020 and 2021). This may include tabulated course evaluation data, tabulated graduate and employer surveys, assessment data for program’s student learning outcomes. (D1 & 3.1)

- Student didactic & clinical records for three cohorts.
  - Didactic courses: show a few current courses in the LMS at the site visit
  - Clinical courses: group by cohort then alphabetically by student. If student records are in a system such as Trajecsys or eValue, program can show records to the team during the visit. (E2.2)

- Signed and dated dosimeter reports or alternative documentation program utilizes for two years prior to those provided in the self-study. (E3.3)