



***Standards for the Accreditation of
Post-Professional Athletic Training Residency Programs***

© Commission on Accreditation of Athletic Training Education

Approved September 26, 2014

Edited: December 4, 2015, January 16, 2017, February 16, 2018

**Standards for the Accreditation of
Post-Professional Athletic Training Residency Programs**

PREFACE

The purpose of the Commission on Accreditation of Athletic Training Education (CAATE) is to develop, maintain, and promote appropriate minimum education standards of quality for athletic training programs. CAATE is sponsored by the American Academy of Family Physicians, the American Academy of Pediatrics, the American Orthopaedic Society for Sports Medicine, and the National Athletic Trainers' Association (NATA).

The Standards and Guidelines for the Accreditation of Post-Professional Athletic Training Residency Programs (Standards) are to be used for the development, evaluation, analysis, and maintenance of post-professional athletic training residency programs. Via comprehensive and annual review processes, CAATE is responsible for the evaluation of a program's compliance with the *Standards*. The *Standards* provide minimum academic requirements; institutions/entities are encouraged to develop sound innovative educational approaches that substantially exceed these *Standards*. The *Standards* document also contains a glossary of terms used throughout the process; the definition provided in the glossary must be applied as stated.

Post-Professional Athletic Training Residency Programs are formal educational programs that offer structured curricula, including didactic and clinical components, to educate Athletic Trainers. They are designed to build upon and expand the Athletic Trainer's knowledge and experience acquired during professional (entry-level) education.

Residency program accreditation is designed to evaluate the post-professional athletic training educational program being offered and is not meant to imply that an Athletic Trainer must participate in an accredited residency to obtain the requisite knowledge and skills necessary for practice in a focused area of clinical practice. The standards allow each post-professional athletic training residency program to be creative and innovative with its program design and the methodologies used to enable Athletic Training residents to achieve program goals and acquire defined competencies.

The accreditation process conducted by the Commission on Accreditation of Athletic Training Education (CAATE) is voluntary and may be pursued by institutions and programs that sponsor a structured educational experience. The process gives applicant programs the opportunity to demonstrate compliance with the approved standards. While the process is voluntary, it provides programs an external validation of their educational offering. Additionally, the process offers prospective athletic training learners a mechanism by which they can judge the quality of the educational experience offered by the program or institution. Programs that successfully demonstrate compliance are accredited

by the CAATE. A list of accredited programs is published and available to the public.

Post-Professional Athletic Training Residency Mission

The mission of a post-professional residency advances preparation of an athletic training practitioner through a planned program of clinical and didactic education in a specialized area utilizing an evidence-based approach to enhance patient care.

Post-Professional Athletic Training Residency Competencies

A Post-Professional Athletic Training Residency (PP-ATR) must prepare athletic trainers for advanced clinical practice that will enhance the quality of patient care, optimize patient outcomes, and improve patients' health-related quality of life through the utilization of evidence-based practice concepts. To realize these objectives, a PP-ATR must ensure that students attain specific "competencies" that relate to professional behaviors.

The Institute of Medicine (IOM) has identified five core competencies for all healthcare providers, regardless of discipline², and similar concepts are represented in six competencies defined by the Accreditation Council for Graduate Medical Education (ACGME)³ and the American Board of Medical Specialties (ABMS)⁴ for all graduate medical education, regardless of specialty. PP-ATR competencies are consistent with those specified by IOM and ACGME/ABMS, and they are consistent with seven foundational behaviors of professional practice identified by the NATA.¹ The six core competencies that a PP-ATR must be designed to address include: 1) patient-centered care, 2) interdisciplinary collaboration, 3) evidence-based practice, 4) quality improvement, 5) use of healthcare informatics, and 6) professionalism. Descriptions of the six core competencies are provided:

1) Patient-Centered Care

Patient-centered care is characterized by efforts to clearly inform, educate, and communicate with patients in a compassionate manner. Shared decision-making and management are emphasized, as well as continuous advocacy of injury and disease prevention measures and promotion of a healthy lifestyle.

Competency in patient-centered care relates to the athletic trainer's ability to serve as an advocate for a patient's best interests, to educate the patient about health-related concerns and intervention options, to recognize any conflict of interest that could adversely affect the patient's health, and to facilitate collaboration among the patient, physician, family, and other members of the patient's social network or healthcare system to develop an effective treatment plan that includes agreed-upon implementation steps, short-term goals and long-term goals.

2) Interdisciplinary Collaboration

Cooperation among clinicians who provide care for a patient is far more important than professional prerogatives and roles. Different health professions often perform a subset of overlapping functions, but separate scopes of practice, governance structures, and standards maintained by licensing agencies for the different health professions present obstacles to the delivery of optimum patient care by an interdisciplinary team.

Competency in interdisciplinary collaboration relates to the athletic trainer's ability to interact with other health professionals in a manner that optimizes the quality of care provided to individual patients.

3) Evidence-Based Practice

Evidence-based practice is the integration of best research evidence with clinical expertise and patient values and circumstances to make decisions about the care of individual patients.

Competency in evidence-based practice relates to the athletic trainer's ability to integrate the best available research evidence with clinical expertise and consideration of patient values and circumstances to optimize patient outcomes.

4) Quality Improvement

Healthcare organizations are increasingly adopting quality assessment methods that originated in the industrial manufacturing sector to minimize waste, decrease errors, increase efficiency, and improve quality of care. Competency in quality improvement relates to the athletic trainer's recognition of the need for constant self-evaluation and life-long learning, and it includes the ability to identify a quality improvement objective, specify changes that are expected to produce an improvement, and quantitatively confirm that an improvement resulted from implementation of the change (e.g., improved patient outcomes from administration of a specific intervention or utilization of a specific protocol).

5) Use of Healthcare Informatics

Clinicians must increasingly use information technology to manage clinical data and access the most recent evidence pertaining to optimum patient care.

Competency in the use of healthcare informatics relates to the athletic trainer's ability to:

- 1) search, retrieve, and utilize information derived from online databases and/or internal databases for clinical decision support,
- 2) properly protect the security of personal health information in a manner that is consistent with legal and ethical considerations for use of such data, including control of data access, utilization of patient identity coding, de-identification of aggregated data, and encryption of electronically transmitted data,
- 3) guide patients to online sources of reliable health-related information,
- 4) utilize word processing, presentation, and data analysis software, and
- 5) communicate through email, text messaging, listservs,

4

and emerging modes of interactive electronic information transfer.

6) Professionalism

Professionalism relates to personal qualities of honesty, reliability, accountability, patience, modesty, and self-control. It is exhibited through ethical behavior, a respectful demeanor toward all persons, compassion, a willingness to serve others, sensitivity to the concerns of diverse patient populations, a conscientious approach to performance of duties, a commitment to continuing education, contributions to the body of knowledge in the discipline, appropriate dress, and maintenance of a healthy lifestyle.

Competency in professionalism relates to the athletic trainer's adherence to the CAATE *Code of Ethics* and the Board of Certification *Standards of Practice*, and includes intrinsic motivation to continuously exhibit the manifestations of professionalism in all aspects of clinical practice and personal conduct.

CAATE Standards for Post-Professional Residency Programs

SPONSORSHIP

1. If the sponsoring organization is an institution of higher education it must be accredited by an agency recognized by the United States Department of Education or by the Council for Higher Education Accreditation and must be legally authorized to provide a program of post-baccalaureate education. If the sponsoring organization is an institution of higher education outside of the United States, the organization must be accredited by a recognized post-baccalaureate accrediting agency.
2. The name “Athletic Training” must appear as part of the residency program identity.
3. All sites where residents are involved in patient care (excluding the residency program’s sponsoring organization) must have an affiliation agreement or memorandum(s) of understanding that is endorsed by the appropriate administrative authority (i.e., those bearing signature authority) at both the sponsoring organization and site. In the case where the administrative oversight of the resident differs from the affiliate site, formal agreements must be obtained from all parties.
4. In certain instances, the sponsoring organization of the residency program may establish affiliation with other units within the organization or at other organizations, to provide instruction, research, or administrative experiences. If such affiliations are made there must be formal administrative arrangements for use of all affiliated settings.
5. If the sponsoring organization is an institution of higher education, the residency program should be housed within the school of health sciences, health professions, medicine or similar health-related academic unit.
6. Residency programs must be conducted only in those practice settings where management and professional staff have committed to seek excellence in patient care, demonstrated substantial compliance with professionally developed and nationally applied practice and operational standards, and have sufficient resources to achieve the educational goals and objectives selected for the residency program.
7. Residency programs, where appropriate, must be conducted only in practice settings that have sought and accepted outside appraisal of facilities and patient care practices. The external appraisal must be conducted by a recognized organization appropriate to the practice setting.
8. If the sponsoring organization is not an institution of higher education it should consult with an individual who is familiar with the development of objectives, outcomes, educational planning, and the assessment process.
9. Two or more practice sites, or a sponsoring organization (e.g., colleges/universities, health system) working in cooperation with one or more practice sites, may provide an athletic training residency.
10. Athletic training residencies must demonstrate the availability of a sufficient

patient population base and professional practice experience to satisfy the requirements of the residency program.

11. Sponsoring organizations must maintain authority and responsibility for the quality of their residency programs.
12. A mechanism must be established that designates and empowers an individual to be responsible for directing the residency program and for achieving consensus regarding the evaluation and ranking of applicants for the residency.
13. All sites where residents are involved in patient care must adhere to the *BOC Facility Principles*

OUTCOMES

14. Develop a Plan: The residency program's outcomes and objectives guide the residency program, and must be consistent with the mission of the sponsoring organization, and the department in which the program is housed.
15. Develop a Plan: All aspects of the residency program (clinical practice, didactic, and scholarly experiences) must have corresponding residency program outcomes and objectives.
16. Develop a Plan: The residency program's outcomes and objectives must reflect its preceptor's expertise and resources.
17. Develop a Plan: The residency program's outcomes must increase residents' depth and breadth of understanding of athletic training subject matter areas, skills, and *Post-Professional Core-Competencies*, beyond the knowledge, skills, and abilities required of a professional preparation program.
18. Develop a Plan: There must be a comprehensive assessment plan to evaluate all aspects of the residency program. Assessments used for this purpose must include those defined in the overall plan. Additional assessments may include, but are not limited to, clinical site evaluations, preceptor evaluations, academic course performance, retention and graduation rates, graduating resident exit evaluations, and alumni placement rates one year post graduation.
19. Develop a Plan: The plan must be ongoing and document regular assessment of the residency program.
20. Assessment Measures: The residency program's assessment measures must include those stated in the overall plan. The specific volume and nature of this information is influenced by the individual character of the organization and should be in keeping with other similar residency programs within the organization. The assessment tools must relate the program's stated educational mission, goals and objectives.
21. Assessment Measures: The residency program's aggregate organizational data (as defined by the CAATE) for the most recent three years must be provided.

(revised January 16, 2017) **(EFFECTIVE JULY 1, 2018)** Standard 21: Assessment Measures: The residency program's aggregate organizational data (as defined *below* by the CAATE) for the most recent three years must be provided.

- *The program's employment rate in athletic training for the most recent three cohorts within 6 months of program completion.*
- *The program's retention and completion rates for the most recent three academic years. (Retention rate (modified from United States Department of Education): Measures the percentage of accepted residents who are seeking who return to the institution to continue their studies the following year. For one-year residency programs, the program will not be required to report retention rate.) (Completion rate (modified from United States Department of Education): Measures the progress of residents who began their studies as full-time residents by showing the percentage of these residents who complete their program within a 150% of "normal time" for completing the program in which they are enrolled.)*

The changes to Standard 21 subsequently impact Standard 22, although the wording of Standard 22 remains the same.

22. Assessment Measures: Residency programs must post the aggregate organizational data (as defined by the CAATE) on the residency program's home page or a direct link to the data must be on the residency program's home webpage.
23. Collect the Data: Residency programs must obtain data to determine all identified residency program outcomes.
24. Data Analysis: Residency programs must analyze the outcomes data to determine the extent to which the residency program is meeting its stated mission, goals, and objectives.
25. Action Plan: The results of the data analysis are used to develop a plan for continual residency program improvement. This plan must:
 - a. Develop targeted goals and action plans if the residency program and resident learning outcomes are not met; and
 - b. State the specific timelines for reaching those outcomes; and
 - c. Identify the person(s) responsible for those action steps; and
 - d. Provide evidence of periodic updating of action steps as they are met or circumstances change.

PERSONNEL

26. The Residency Program Director must be a full-time employee of the sponsoring organization.
27. The Residency Program Director should have a minimum of five years of athletic training practice experience.
28. The Residency Program Director should have demonstrated mastery of the knowledge, skills, attitudes, and abilities expected of one who has completed a residency.
29. The Residency Program Director must have programmatic administrative and supervisory assignment that is consistent with other similar assignments within the organization.
30. Each residency program must have a single Residency Program Director who must be an athletic trainer from a practice site involved in the program or from a

sponsoring organization.

31. A single Residency Program Director must be designated for multiple-site residencies or for a residency offered by a sponsoring organization in cooperation with one or more practice sites.
32. The responsibilities of the Residency Program Director must be defined clearly, including lines of accountability for the residency and to the residency training site.
33. The designation of this individual to be Residency Program Director must be agreed to in writing by responsible representatives of each participating organization.
34. The Residency Program Director must have demonstrated their ability to direct and manage an athletic training residency. This may include, but is not limited to previous involvement as a preceptor in a CAATE accredited athletic training residency program, management experience, or previous clinical instruction or supervision experience.
35. The Residency Program Director must have a sustained record of contribution and commitment to athletic training practice. The record may include, but is not limited to, the following characteristics:
 - a. Documented record of improvements in and contributions to athletic training practice.
 - b. Formal recognition by peers or supervisors as a model practitioner.
 - c. An ongoing record of continued contribution to the total body of knowledge in athletic training through publications in professional journals and/or presentations at professional meetings.
 - d. Serves as a reviewer of manuscripts submitted for publication.
 - e. Demonstrated leadership in advancing the profession of athletic training through active service in professional organizations and activities at the local, state, and national levels.
 - f. Demonstrated effectiveness in teaching (e.g., through student and/or resident evaluations, teaching awards).
36. The Residency Program Director must have administrative release time. The Residency Program Director's release time must be equivalent to similar residency programs in the organization. If no such similar program exists at the organization, then benchmark with peer organizations.
37. The Residency Program Director's responsibilities must include input to and assurance of the following residency program features:
 - a. Ongoing compliance with the *Standards*;
 - b. Planning, development, implementation, delivery, documentation, and assessment of all components of the residency program;
 - c. Clinical practice experiences;
 - d. Programmatic budget.
38. The Residency Program Director must be certified and be-in good standing with the Board of Certification (BOC).
39. The Residency Program Director must possess a current state athletic training credential and be in good standing with the state regulatory agency (where applicable).

40. The Residency Program Director must have documented evidence of his/her own ability to teach effectively in the clinical practice environment (e.g., through student and/or resident evaluations).
41. The Residency Program Director must mentor the preceptors as they interact with the resident.
42. The residency program must provide a sufficient complement of associated clinical staff (preceptors and other clinicians) to ensure appropriate support and guidance to all residents.
43. Based on the residency program's resident enrollment, the number of clinical staff (preceptors and other clinicians) must be sufficient to meet residency program outcomes.
44. A preceptor must function to:
 - a. Mentor residents during clinical practice to expand their depth and breadth of knowledge and skills in the programs focused area of clinical practice;
 - b. Provide instruction and assessment of the advanced knowledge, skills, and clinical abilities of the focused area of clinical practice designated by the program;
 - c. Provide instruction and opportunities for the resident to develop advanced clinical integration proficiencies, communication skills, and clinical decision-making during actual patient/client care;
 - d. Provide assessment of athletic training residents' clinical integration proficiencies, communication skills and clinical decision-making during actual patient/client care;
 - e. Facilitate the clinical integration of advanced skills, knowledge, and evidence regarding the practice of athletic training in the programs focused area of clinical practice.
45. A preceptor must demonstrate understanding of and compliance with the program's policies and procedures.
46. A preceptor must be credentialed by the state in a health care profession.
47. All preceptors must have training and experience in the focused area of clinical practice for which they serve as preceptors, must maintain continuity-of practice in that area, and must be practicing in that area at the time residents are being trained.
48. A preceptor must receive planned and ongoing education from the program designed to promote a constructive learning environment.

49. Preceptors must have a record of contribution and commitment to their focused area of clinical practice. The record may include, but is not limited to, the following characteristics:
 - a. Documented record of improvements in and contributions to their focused area of practice.
 - b. Formal recognition by peers or supervisors as a model practitioner.
 - c. An ongoing record of continued contribution to the total body of knowledge in their specified area of practice through publications in professional journals and/or presentations at professional meetings.
 - d. Serves as a reviewer of manuscripts submitted for publication.
 - e. Demonstrated leadership in advancing their profession through active service in professional organizations and activities at the local, state, and national levels.
 - f. Demonstrated effectiveness in teaching (e.g., through student and/or resident evaluations, teaching awards).
50. The residency program must have a Medical Director. This individual must be an MD/DO who is licensed to practice in the state sponsoring the program.
51. The Medical Director must, in coordination with the Residency Program Director, serve as a resource and medical content expert for the residency program.

RESIDENCY PROGRAM DELIVERY: Residency program delivery includes didactic, scholarly, and advanced clinical practice opportunities.

52. The residency program must provide defined and planned didactic education experiences in a focused area of clinical practice within the scope of athletic training.
53. The residency program must provide a defined and planned scholarly experience within the focused area of clinical practice.
54. The residency program must assure that the *Post-Professional Core Competencies* are integrated within the program.
55. Clinical placements must be non-discriminatory with respect to race, color, creed, religion, ethnic origin, age, sex, disability, sexual orientation, or other unlawful basis.
56. All sites must be evaluated by the residency program on an annual and planned basis and the evaluations must serve as part of the residency program's comprehensive assessment plan.
57. The residency program's residents must be credentialed and be in good standing with the Board of Certification (BOC) prior to providing athletic training services.
58. The residency program's residents must possess a current state athletic training credential and be in good standing with the state regulatory agency (where applicable) prior to providing athletic training services.
59. Planned and ongoing educational opportunities (minimum requirement of five hours per week) must be documented that the resident must complete throughout the residency. These may include, but are not limited to, case reviews, didactic classroom instruction, journal club, problem solving sessions, clinical rounds, in-services, seminars, workshops, etc.).

60. The number of work hours performed during the residency program must be in compliance with organizational and Federal policy and must not exceed the duty hour standards of the Accreditation Council for Graduate Medical Education (ACGME).
61. The residency program must provide opportunities for the residents to instill the principles of evidence-based practice to include, but not limited to, reading and interpreting available patient oriented evidence and integrating into clinical practice.
62. The residency program must provide opportunities for residents to identify, assimilate, and review research within the focused area of clinical practice and disseminate the information that has been compiled.
63. The residency program must incorporate the principles of evidence based practice and include the measurement of patient oriented evidence to determine the effectiveness of athletic training interventions.
64. The resident must actively engage in measuring patient oriented outcomes as part of systematic data collection and ongoing assessments within the focused area of clinical practice and disseminate the information that has been compiled.
65. Residents must receive formal and informal feedback regarding their performance at regularly planned intervals.
66. There must be an individualized advanced clinical education plan (individual goals and/or objectives) for each resident to improve the residents' ability to provide patient care.
67. Residency programs must be a minimum of twelve consecutive months with a continuous full-time practice commitment.
68. The Residency Program Director must ensure that neither the educational outcomes of the program nor the welfare of the resident or the welfare of patients are compromised by excessive reliance on residents to fulfill service obligations.
69. The Residency Program Director and, when applicable, preceptors must conduct essential orientation activities. Residents must be oriented to the program to include its purpose, the applicable accreditation regulations and standards, designated learning experiences, and the evaluation strategy. When necessary, the Residency Program Director will orient staff to the residency program. Preceptors will orient residents to their learning experiences, including reviewing and providing written copies of the learning experience educational goals and objectives, associated learning activities, and evaluation strategies.

FINANCIAL RESOURCES

70. The residency program must receive adequate, equitable, and annually available resources necessary to meet the program's needs based on the program's size and documented mission and outcomes. Funding must be commensurate with other comparable residency programs. If no such similar residency program exists at the organization, then benchmark with residency programs at peer organizations.
71. The residency program must provide residents' sufficient financial support to fulfill the responsibilities of the program.

FACILITIES AND INSTRUCTIONAL RESOURCES

72. Clinical and didactic space must be sufficient to deliver the residency program.
73. The number and quality of instructional aids must meet the needs of the residency program's focused area of clinical practice.
74. Library and/or other Information Sources: Residents must have reasonable access to the information resources needed to adequately prepare them for advanced practice and to support the *Post-Professional Core Competencies*. This includes current electronic or print editions of books, periodicals, and other reference materials and tools related to the program outcomes.
75. Offices must be provided for residency program staff on a consistent basis to allow for program administration and confidential resident counseling.
76. The residency program must provide residents an area in which to work.

OPERATIONAL POLICIES AND FAIR PRACTICES

77. Standards and criteria for Residency Program admission and retention must be identified and publicly accessible.
78. Employment practices must be non-discriminatory with respect to race, color, creed, religion, ethnic origin, age, sex, disability, sexual orientation, or other unlawful basis.
79. The residency program must assure equal opportunity for didactic instruction, clinical experience, and other educational activities for all residents in the program.
80. All program documents must use accurate terminology of the profession and residency program offered (e.g., BOC certification, accreditation status, and the residency program title of athletic training).
81. All required program specific costs incurred by the resident must be publicly accessible in official organizational documents.
82. Acceptance by residents of these terms and conditions must be documented prior to the beginning of the residency.
83. Organizational policies concerning professional, family, and sick leave and the effect such leaves would have on the resident's ability to complete the residency program must be defined, published, and readily available.
84. The resident must be appropriately credentialed to practice athletic training in the state of the residency.
85. The residents' primary professional commitment must be a full-time obligation to the residency program.

PROGRAM DESCRIPTION AND REQUIREMENTS

86. Preceptors and residents must have a clearly written and consistent description of the residency program available to them.
87. The description of the residency program must include residency program mission, outcomes and objectives.
88. The description of the residency program must include didactic and clinical practice sequence.
89. The description of the residency program must include program requirements for completion of the residency.
90. The sponsoring organization must have a published procedure available for

processing resident and preceptor grievances.

91. Policies and processes for resident withdrawal and termination must be published in official organizational publications or other announced information sources and made available to applicants.
92. Policies and procedures governing the award of available funding for scholarships administered by the program must be accessible by eligible residents.
93. The residency program must provide defined, planned and mentored education and training in a focused area of clinical practice within the scope of athletic training.
94. The organization offering the residency program must provide an exemplary clinical practice environment and mentored athletic training experience.
95. The residency program must document that the clinical practice environment involves a defined and planned experience within a focused area of clinical practice within the scope of athletic training.
96. The majority of the clinical experience must be completed within the focused area of clinical practice, and at least 20% of the time must occur with the preceptors in a one-on-one basis within that focused area.
97. Residents should be employees of the sponsoring organization.

STUDENT RECORDS

98. The residency program must maintain appropriate resident records demonstrating progression through the residency program.
99. The residency program must maintain appropriate resident records. These records, at a minimum, must include residency program admission application and supporting documents.
100. The residency program must maintain appropriate resident records. These records, at a minimum, must include remediation and disciplinary actions (when applicable).
101. The residency program must maintain appropriate resident records. These records, at a minimum, must include clinical practice experiences.
102. Resident records must be stored in a secure location(s), either electronic or in print, and be accessible to only designated residency program personnel.

(revised January 16, 2017) **EFFECTIVE JULY 1, 2017** - New Standard: *The sponsoring organization must demonstrate honesty and integrity in all interactions that pertain to the athletic training program.*

Clarification effective November 30, 2015: Inherent in any Standards that pertain to establishing policy is the assumption that the programs must also abide by those policies. Failure to do so will be cited as non-compliant with the associated Standard.

Glossary

Competency. Professional behavior that involves *the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice.* ²

Focused area of clinical practice within the scope of athletic training: An area of clinical practice that can be clearly denoted as being advanced in depth of knowledge and skills. The purpose of this focused depth is to develop specialists in sub-disciplines within athletic training. Areas of focused practice depth should be developed around the focused patient population (eg, pediatrics) or body system (eg, orthopedics/musculoskeletal). Areas of focused clinical practice should NOT be developed based upon practice setting (eg, secondary school, hospital, industrial). Programs are encouraged to examine the residency models of specialization in peer health professions such as medicine, pharmacy, and physical therapy when determining an appropriate focused area of clinical practice. Programs bear the burden of establishing why their chosen focused area of clinical practice is appropriate to advance the residents depth of knowledge and skills in a specialized area of athletic training practice.

Guideline: Requirements that are so important that their absence must be justified. Denoted by the verb “should.”

Multiple-site residency. A residency site structure in which multiple organizations/practice sites are involved in the residency program. In a multiple-site residency, a sponsoring organization must be identified to assume ultimate responsibility for coordinating and administering the program.

Must: Verb used to indicate that something is required, compelled, mandatory or shall be done without fail. It connotes an absolute requirement. A Standard.

Preceptor. An expert clinician who provides practical experience and training to an athletic training resident. Preceptors responsibilities include development of a resident’s practice competency, therefore it is critical that learning experiences be mentored by preceptors who model clinical practice skills and provide regular criteria-based feedback. It is permissible to use practitioners in addition to athletic trainers (e.g., physicians, physician assistants, and nurse practitioners) as preceptors.

Residency program director. The athletic trainer responsible for direction, conduct, and oversight of the residency program.

Single-site residency. A residency site structure in which the practice site assumes total responsibility for the residency program. In a single-site residency, the majority of the resident’s training program occurs at the site; however, the resident may spend assigned time in short elective learning experiences off-site.

Should. A term used to designate requirements that are so important that their absence must be justified. A program is at risk if it is not in compliance with a "should". A guideline.

Sponsoring organization. The organization assuming ultimate responsibility for the coordination and administration of the residency program. The sponsoring organization is charged with ensuring that the resident experiences are educationally sound and are conducted in a quality practice environment. The sponsoring organization is also responsible for submitting the accreditation application and ensuring periodic evaluations are conducted. If several organizations share responsibility for the financial and management aspects of the residency the organizations must mutually designate one organization as the sponsoring organization.

Standard: Mandatory components of the program. Denoted by the verb “**must**” and “**shall.**”

*modified from the ASHP Accreditation Materials (www.ashp.org), ARC-PA Accreditation Materials, and APTA Accreditation Materials.

REFERENCES

1. National Athletic Trainers' Association: *Athletic Training Educational Competencies*. 5th ed., Dallas, TX: NATA, 2011. <http://www.caate.net> Accessed September 2012.
2. Institute of Medicine: *Health Professions Education: A Bridge to Quality*. Washington, D.C.: National Academy Press, 2003.
3. Accreditation Council for Graduate Medical Education: *Common Program Requirements: General Competencies*. Available at: <http://www.acgme.org/outcome/comp/GeneralCompetenciesStandards21307.pdf>.
4. American Board of Medical Specialties: Maintenance of Certification; Competencies and Criteria. Available at: [http://www.abms.org/Maintenance of Certification/MOC competencies.aspx](http://www.abms.org/Maintenance%20of%20Certification/MOC%20competencies.aspx)
5. American Society of Health-System Pharmacists Accreditation Materials (www.ashp.org)
6. Accreditation Review Commission on Education for the Physician Assistant, Inc. Accreditation Materials (<http://www.arc-pa.org>)
7. American Physical Therapy Association Accreditation Materials (www.apta.org)