

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
Board of Directors Meeting, San Antonio, Texas
December 4, 2009

Minutes

Attendance

Tim Myers, BS, RRT-NPS, President
Toni Rodriguez, EdD, RRT, Past President
George Gaebler, MEd, RRT, FAARC, VP/Internal Affairs
Joseph Lewarski, BS, RRT, FAARC, VP/External Affairs
Karen Stewart, MS, RRT, FAARC, Secretary-Treasurer
Patricia Doorley, MS, RRT, FAARC
Debbie Fox, MBA, RRT-NPS
Lynda Goodfellow, EdD, RRT, FAARC
Michael Hewitt, RRT-NPS, FAARC, FCCM
Denise Johnson, BS, RRT
Ruth Krueger, RRT, MS, CHC
Douglas Laher, BSRT, RRT, MBA
John Lindsey, RRT
Robert McCoy, RRT, FAARC
Doug McIntyre, MS, RRT, FAARC
Frank Salvatore, MBA, RRT, FAARC
James Taylor, PhD, RRT
Michael Tracy, BA, RRT-NPS, CPFT
Brian Walsh, RRT-NPS, RPFT

Guests

David Bowton
Tom Smalling

Consultants

John Hiser, MEd, RRT, FAARC, Parliamentarian
Dianne Lewis, MS, RRT, FAARC, President/Presidents Council
Kent Christopher, MD, RRT FAARC, BOMA Chair

Staff

Sam Giordano, MBA, RRT, FAARC, Executive Director
Tom Kallstrom, BS, RRT, AE-C, FAARC, Chief Operating Officer
Ray Masferrer, RRT, FAARC, Associate Executive Director
Steve Nelson, RRT, FAARC, Associate Executive Director
William Dubbs, MHA, MEd, RRT, Director of Education and Management
Ann Marie Hummel, Regulatory Affairs Director
Miriam O'Day, Federal Government Affairs Director
Cheryl West, State Government Affairs Director
Tony Lovio, Controller
Brenda DeMayo, Administrative Coordinator

CALL TO ORDER

President Tim Myers called the meeting of the AARC Board of Directors to order at 8:30 a.m. CST, Friday, December 4, 2009.

Secretary-Treasurer, Karen Stewart called the roll and declared a quorum.

TENNESSEE SOCIETY LETTER

President Tim Myers distributed copies of a letter from the Tennessee Society for Respiratory Care stating their concerns over the Board withholding revenue sharing checks from the Tennessee Society.

HOUSE OF DELEGATES RESOLUTIONS

Frank Salvatore moved to accept **HR 16-09-15** “Resolved that the AARC Executive Office explore and consider implementing a new discounted membership category for members who are over the age of 65.”

George Gaebler moved “To refer **HR 16-09-15** to the Executive Office to investigate and bring back at the summer meeting of 2010.”

Motion to Refer Carried

COMMITTEE ON ACCREDITATION FOR RESPIRATORY CARE (CoARC) REPORT

2010 CoARC Chair David Bowton and Executive Director Tom Smalling reported on CoARC’s activities. They are seeking CHEA recognition which they expect to obtain in the coming year. Phase out of the 100-level program is underway. They are in the process of website reconstruction which will be available in early spring. CoARC recently acquired a new accounting firm, and are also contracting with Liaison International. The new draft standards which were approved by the CoARC Board is now in the hands of their sponsors.

POLYSOMNOGRAPHY DOCUMENT

“The Scope of Practice for Polysomnographic (Sleep) Technologies” approved by the AASM and dated November 7, 2009 was distributed to members to review. It was noted that there were several changes yet to be made. Therefore, members will review and send their changes over the Listserv and the Executive Office will get back with the AASM with a revised draft document.

RECESS

President Tim Myers recessed the meeting of the AARC Board of Directors at 9:50 a.m. CST, Friday, December 4, 2009.

RECONVENE

Past President Toni Rodriguez reconvened the meeting of the AARC Board of Directors at 10:15 CST, Friday, December 4, 2009.

ORGANIZATIONAL REPRESENTATIVES REPORTS

AMERICAN ASSOCIATION OF CARDIOVASCULAR AND PULMONARY REHABILITATION (AACVPR) REPORT

Joe Lewarski moved to accept **Recommendation 09-3-61.1** “That the AARC provide continued support of this liaison position to the AACVPR as the Chair of the Continuing Care/Rehab Section.”

Karen Stewart moved “To accept **Recommendation 09-3-61.1** for information only.”

Motion Carried

AMERICAN HEART ASSOCIATION REPORT

_____ moved to accept **Recommendation 09-3-63.1** “That the AARC continue to support a representative to AHA to assist in development of guidelines.”

Karen Stewart moved “To accept **Recommendation 09-3-63.1** for information only since this is already in the budget.”

Motion Carried

COMMITTEE ON ACCREDITATION OF ALLIED HEALTH EDUCATION PROGRAMS (CAAHEP)

President Tim Myers reported this organization will no longer be represented by AARC and therefore should be removed from the agenda and from the organizational representatives list.

JOINT COMMISSION ON ALLIED HEALTH ORGANIZATIONS (JCAHO) REPORT

President Tim Myers reported that this organization's name has changed to "The Joint Commission" and should be changed on the agenda and the organizational representative list.

SIMULATION ALLIANCE REPORT

Patricia Doorley moved to accept **Recommendation 09-3-78.1** "That the AARC participate in and advertise through their normal marketing channels an upcoming project being organized for the purpose of drafting standards for using lung simulators for ventilator testing and for which Robert Chatburn will be the facilitator."

Karen Stewart moved "To refer **Recommendation 09-3-78.1** to the President."

Motion to Refer Carried

ACCEPTANCE OF ORGANIZATIONAL REPRESENTATIVE REPORTS

Joe Lewarski moved "To accept the organizational representative reports as presented."

Motion Carried

POLICY REVIEW

Ruth Krueger moved "To accept **Policy BOD 004 – Continuous Quality Improvement Plan.**" (See ATTACHMENT "C")

Ruth Krueger moved "To move 'continually' to precede 'evaluate' under the title Policy Statement, and replace 'products' with 'services' in the 7th bulletpoint."

Motion Carried – Insert December 2009 under Date Revised.

Ruth Krueger moved "To accept **Policy HOD 001 – Correspondence.**" (See ATTACHMENT "C")

Motion Carried – Insert December 2009 under Date Revised.

Patricia Doorley moved "To accept **Policy HOD 002 – Procedures/Rules**" (See ATTACHMENT "C")

Motion Carried – Insert December 2009 under Date Reviewed.

Ruth Krueger moved “To accept **Policy MP 001 – General Operating Policies.**” (See ATTACHMENT “C”)

Ruth Krueger moved “To amend Policy Amplification #6 as follows:

All AARC members shall receive a communication of congrats and thanks from the President and Executive Director at 20 years and each subsequent decade of continuous membership.

Motion to Amend Carried – Insert December 2009 under Date Revised

Amended Motion Carried

James Taylor moved “To accept **Policy CT 002 – Medical Advisors.**” (See ATTACHMENT “C”)

Motion Carried – Insert December 2009 under Date Reviewed

NEW BUSINESS

AD HOC COMMITTEE ON MASS CASUALTY AND PANDEMIC ISSUES

George Gaebler moved to accept **FM 09-3-33.1** “To approve renaming and restructuring the previous three Ad Hoc Committees on Ventilator Capability and Capacity, Human Resources, and Logistics to encompass one Ad Hoc Committee entitled Ad Hoc Committee on Mass Casualty and Pandemic Issues.”

Motion Carried

INTERNATIONAL ROUNDTABLE RESEARCH PROPOSAL

Mike Tracy moved to accept **FM 09-3-48.1** “To accept the International Roundtable Research Proposal.”

Mike Tracy moved “To refer **FM 09-3-48.1** to the President to send back to the originator for clarification and narrowing the scope and name change. In the interim the Executive Office will confirm whether the 10 names are actual AARC members and this will be brought back at the spring meeting in April.”

Motion to Refer Carried

Past President Toni Rodriguez passed the gavel back to President Myers at 11:10 a.m. CST, Friday December 4, 2009.

GERIATRIC ROUNDTABLE PROPOSAL

George Gaebler moved to accept **FM 09-03-44.1** “That the AARC accept approval of the Geriatric Roundtable which would replace the Ad Hoc Geriatric Committee.”

George Gaebler moved “To refer **FM 09-03-44.1** to the President to establish goals and assign a chair.”

Motion to Refer Carried

BOMA SWAT TEAM

Kent Christopher asked members to consider a SWAT team of physicians that members can go to for medical information and resources that would be optional for states and international groups.

President Myers asked members to consider this concept, and it will be discussed at the Spring meeting.

AARC VIRTUAL MUSEUM

Karen Stewart moved to bring back to the table **Recommendation 09-2-8.2** “That the AARC Board of Directors investigate the feasibility of creating a ‘virtual museum’ for the Association and the profession of respiratory care” and **Recommendation 09-2-8.3** “That the AARC Board investigates the feasibility of creating and sustaining a museum for respiratory care in proximity to the AARC Executive Office.”

Karen Stewart moved “To refer **Recommendation 09-2-8.2 and Recommendation 09-2-8.3** to the President to set up an ad hoc committee to investigate feasibility and establish goals and objectives on how to move this forward by the summer meeting of 2010.”

Motion to Refer Carried

ELECTRONIC BOARD REPORTING MECHANISM

President Tim Myers asked members to report on their experiences with the electronic board reporting system. Comments follow:

- Charges weren’t listed on the report this time.
- Browser problems – Seems that if it works for the AARC system, it doesn’t work on the system used by the reporter.
- VP didn’t receive the notice that reports were ready for review.
- Add Board or BOMA Liaison on report, justification for recommendations, charges

- Charges set up individually with a space to type something under it.
- Attachments still a problem
- Create a field to fill in a blank for section numbers.
- Create a mechanism for tracking recommendations in a database.
- Create one document for charges and one document for recommendations
- Liaisons to get copies of reports too
- It “times out” before reporter can finish the report.

Steve Nelson stated that Higher Logic ties in with our database. A prototype will be demonstrated at the April meeting.

2010 HOUSE OF DELEGATES ELECTIONS

The 2010 House officers are as follows:

Speaker	Tom Lamphere
Past Speaker	Cam McLaughlin
Speaker-elect	Bill Lamb
Secretary	Sherry Tooley Peters
Treasurer	Deb Skees
Parliamentarian	Garry Kauffman

DONATION FOR INTERNATIONAL PROGRAM

John Hiser reported that \$10,000 was raised by the House of Delegates in support of the International Program.

OUTGOING BOARD MEMBERS

President Tim Myers acknowledged Ruth Krueger, John Lindsey, and Mike Tracy whose terms end in 2009 and stated his appreciation for their service to the Association.

TREASURER’S MOTION

Secretary-Treasurer Karen Stewart moved “That the expenses incurred at this meeting be reimbursed according to AARC policy.”

Motion Carried

Karen Stewart moved “To adjourn the meeting of the AARC Board of Directors.”

Motion Carried

ADJOURNMENT

President Tim Myers adjourned the meeting of the AARC Board of Directors at 12:40 p.m. CST, Friday, December 4, 2009.

ATTACHMENT “A”

Position Statements

American Association for Respiratory Care

9425 N. MacArthur Blvd, Suite 100, Irving, TX 75063

Position Statement

Age Appropriate Care of the Respiratory Patient

Patients with respiratory disease should receive the highest quality of care in a timely and professional manner. Respiratory Therapists (RTs) have the training and expertise to deliver respiratory care to all age groups, from neonate to elderly. RTs are trained, tested, uniquely qualified, and specifically credentialed to provide respiratory care as attested in official supporting statements by the American Society of Anesthesiologists (ASA), the American College of Chest Physicians (ACCP), and the National Association for Medical Direction of Respiratory Care (NAMDRC).

RTs provide services to all age groups across the continuum of care, including physician's offices, acute care hospitals, sub-acute care facilities, rehabilitation facilities, skilled nursing facilities, hospice facilities, and patients' homes. RTs should participate in the initial assessment of the patient to maximize the effective and efficient use of respiratory care service resources. The RT should work under a medical director and provide respiratory care services under medical direction, as ordered by a physician and/or in accordance with a prescribed respiratory care protocol or clinical pathway, and should offer recommendations for an appropriate regimen of care. RTs should be a part of the team providing education of the patient, family members, and other health caregivers regarding respiratory care to ensure appropriate disease management.

In accordance with the recommendations of two Education Consensus Conferences, the American Association for Respiratory care (AARC) encourages respiratory care educators/managers to include: a gerontology module in respiratory care training program curricula, and clinical training at long term care and rehabilitation facilities to provide students with the opportunity to learn how to appropriately plan for and provide respiratory care services for geriatric patients. Topics focused on the geriatric patient and his/her special health care needs in departmental continuing education programs to assure the desired quality of care for this patient population, and to meet the requirements of health care organization accreditation for age-specific professional training.

Effective 1997
Reviewed 2001
Revised 2005

American Association for Respiratory Care

9425 N. MacArthur Blvd, Suite 100, Irving, TX 75063

Position Statement

Transport of the Mechanically Ventilated, Critically Injured or Ill, Neonate, Child or Adult Patient

Transport of the mechanically ventilated, critically injured or ill neonatal, pediatric and/or adult patient is always associated with a degree of risk. Whether these transports are considered external transports -- from one facility to another -- or internal transports -- from one area to another within a facility or system -- the risk needs to be minimized through careful preparation prior to the transport, continuous monitoring throughout the transport, and the use of appropriate transport equipment and personnel.

The American Association for Respiratory Care recognizes the following as the minimum standards for the safe transport of the mechanically ventilated, critically injured or ill, patient:

1. Transports will be performed by a team consisting of, at a minimum, a Certified or Registered Respiratory Therapist and a Registered Nurse with critical care experience.
2. One member of the transport team will have the appropriate advanced life support certification (NRP, PALS and/or ACLS).
3. A minimum of one member of the transport team will be competent in airway management. Appropriate airway management equipment will be readily available during the transport.
4. Transport monitors will provide real time measurement of all essential parameters.
5. All patients receiving mechanical ventilation will have some form of carbon dioxide monitor in place during transport as this monitor is useful in providing information regarding both airway placement and pulmonary blood flow.
6. A transport ventilator, or transport capable ICU ventilator, will be utilized for mechanical ventilation when possible.
7. A self inflating bag/valve/mask resuscitation device will accompany all patients on transport in case of ventilator failure, gas failure, or accidental extubation.
8. A trial of mechanical ventilation using the planned transport device will be conducted to assess patient tolerance and stability before proceeding with the transport whenever possible.

9. Appropriate and thorough documentation, using the facility's designated process, will occur for all stages of the transport in accordance with the facility's policies and procedures.

Developed: 11/10/2009

American Association for Respiratory Care

9425 N. MacArthur Blvd, Suite 100, Irving, TX 75063

Position Statement

Delivery of Respiratory Therapy Services in Long Term Care Facilities

Long term care facilities are increasingly becoming the venue for the management of patients who require the full array of respiratory therapy services, from oxygen therapy and inhalation medication management to pulmonary rehabilitation and ventilator management. Long term care facilities should recognize the clinical value to the patient of utilizing a respiratory therapist to provide the complete spectrum of services that respiratory therapists are both educated and competency tested to provide.

The American Association for Respiratory Care recommends that the basic standard of care for long term care facilities be to employ Respiratory Therapists to render care to patients requiring mechanical ventilation. Additionally, the following basic standards are recommended to ensure the safe and efficient delivery of respiratory therapy services in long term care facilities:

1. A Certified, or Registered, Respiratory Therapist -- licensed by the state in which he/she is practicing if applicable -- will be on site at all times to provide ventilator care, monitor life support systems, administer medical gases and aerosol medications, and perform diagnostic testing.
2. A Pulmonologist, or licensed physician experienced in the management of patients requiring respiratory care services (specifically ventilator care), will direct the plan of care for patients requiring respiratory therapy services.
3. The facility will establish admission criteria to ensure the medical stability of patients prior to transfer from an acute care setting.
4. Facilities will be equipped with technology that enables it to meet the respiratory therapy, mobility and comfort needs of its patients.
5. Clinical assessment of oxygenation and ventilation – arterial blood gases or other methods of monitoring carbon dioxide and oxygenation – will be available on site for the management of patients receiving respiratory therapy services at the facility.

6. Emergency and life support equipment, including mechanical ventilators, will be connected to electrical outlets with backup generator power in the event of power failure.
7. Ventilators will be equipped with internal batteries to provide a short term back-up system in case of a total loss of power.
8. An audible, redundant ventilator alarm system will be located outside the room of a patient requiring mechanical ventilation to alert caregivers of a ventilator malfunction/failure or a patient disconnect.
9. A backup ventilator will be available at all times that mechanical ventilation is being provided to a patient.

Developed: 10/2009

ATTACHMENT “B”

Protocol Statement

American Association for Respiratory Care

Guidelines for Respiratory Care Department Protocol Program Structure

Ford Version 11.10.2008

The American Association for Respiratory Care (AARC) is the leading national and international professional association for respiratory care. The AARC encourages and promotes professional excellence, advances the science and practice of respiratory care, and serves as an advocate for patients, their families, the public, the profession and the respiratory therapist. The AARC recognizes and supports the use of therapist implemented protocols defined as:

*Initiation or modification of a patient care plan following a predetermined structured set of physician orders, instructions or interventions in which the therapist is allowed to initiate, discontinue, refine, transition, or restart therapy as the patient's medical condition dictates. **Note:** This definition should not be confused with programs that include discontinuation of therapy without a reorder, flagging therapy for physician reorder, standing orders or policies that dictate therapy durations*

Current medical literature supports the use of therapist implemented protocols as an effective tool for producing improved patient outcomes and appropriate allocation of services. Protocols have been attributed with:

- Helping respiratory therapists deliver appropriate and efficient care under conditions of an increased workload
- Assuring that all treatments have established indicators
- Reducing the volume of unnecessary care.

Evidence based literature supports the use of protocols to minimize unnecessary treatments and provide self-administration options for patients who demonstrate their ability to do so. Based on the demonstrated efficacy of therapist implemented protocols, it is the position of the American Association for Respiratory Care that

institution-approved protocols should be used by respiratory therapists as the standard of care for providing respiratory therapy services under qualified medical direction.

It is recognized that the characteristics and structure of protocol programs throughout the country have some variability secondary to facility specific policy and practice. All programs however must comply with Federal and State regulations and standards including those published by their State Licensing Boards, The Joint Commission as well as the Centers for Medicare and Medicaid Services. The AARC recommends that a policy and procedure governing the application of therapist implemented protocols be developed. The following policy guidelines are intended to promote compliance with such standards, however each department must refine their specific programs to insure regional compliance. Those responsible for drafting protocols and related policy should incorporate the following recommendations:

- Department policy must specify which respiratory therapists can deliver care outlined in the protocol, inclusive of the competencies required of individuals and demonstration of skills and knowledge.
- Medical Director oversight and accountability for services provided using protocols must also be specified in department policy.
- The protocols should be written to reflect the indications, precautions, and therapy specifics as outlined in the AARC Clinical Practice Guidelines, or other evidence based references.
- All policies related to protocols, as well as the protocols themselves, must be approved by the appropriate institutional governing bodies. .
- Policies for protocols must be compliant with other institutional policies related to the provision of care, with specific attention to pharmacy and nursing services. Because many therapist implemented protocols involve the administration of medication, there must be a single standard throughout the facility regarding the procurement, control and administration of medications.
- A physician order is required to implement respiratory therapy managed by protocols. The order may include a request for "Respiratory Protocol", a specific request such as "MDI Protocol"

or other order details as specified and approved by the Medical Staff. (It should be noted that this is an area of contention with some surveying agencies when they encounter a facility that does not require a physician order)

- Protocols must include criteria, thresholds, and decision points that require the physician be notified for continuation of the protocol, options to consider including exemption from protocol with requirements for new non-protocol orders.
- Policy should also define emergent situations in which respiratory therapists can immediately initiate protocols without a physician order. Protocols initiated in this manner shall be reviewed and authorized by physician signature within 24 hours.
- A quality assurance mechanism should be in place to assess if the respiratory therapist is providing care in compliance with protocol as well as capturing adverse responses.

ATTACHMENT “C”

Policy Review

Policy Review

July, 2009

BOD 004 (Referral to Toni Rodriguez)

HOD 001

HOD 002

MP 001

CT 002

American Association for Respiratory Care Policy Statement

Page 1 of 2
Policy No.: BOD.004

SECTION: Board of Directors
SUBJECT: **Continuous Quality Improvement Plan**
EFFECTIVE DATE: December 1999
DATE REVIEWED: **December 2009**
DATE REVISED: **December 2009**

REFERENCES:

Policy Statement:

The Board of Directors shall **continually** evaluate its effectiveness as the governing entity of the Association.

Policy Amplification:

1. As part of this process, the Board of Directors **shall review planning, operation and service delivery to assure quality performance of the Association** based upon key quality precepts.

Quality Performance

The Board of Directors is responsible for the efficient use of available resources to operationalize the mission statement and attain the strategic objectives of the AARC. Quality performance occurs through the continuous improvement of key processes and activities that contribute to the advancement of the art and science of respiratory care irrespective of venue.

Quality Precepts

- Continuous improvement of every process of planning operation and service delivery.
- Elimination of barriers which have the effect of adding costs through waste reduction and simplification.

American Association for Respiratory Care Policy Statement

Page 2 of 2
Policy No.: BOD.004

- Alignment with outside organizations as partners.
- Management practices that focus on improvement of the systems in which members work.
- Emphasis on continuous process improvement rather than periodic inspection
- Continuous evaluation and improvement of working relationships with related organizations.
- Promotion of member understanding of their jobs and individual roles in providing quality services.
- Creation of a caring organizational environment that is characterized by trust and integrity and strives to drive out fear and frustration for optimal performance; encourages suggestions for improvement and innovation; and promotes sharing of ideas.
- Communication about organizational goals and progress as essential for enlisting effective participation.
- Creation of budgets and performance management each year for monitoring progress internally.
- Improvement in statistical processes and planning, and application of quantitative methods for continued improvement.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care Policy Statement

Page 1 of 1
Policy No.: HOD.001

SECTION: House of Delegates

SUBJECT: **Correspondence**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED:

DATE REVISED:

REFERENCES:

Policy Statement:

Correspondence and other information relevant to the function of the House of Delegates shall be appropriately routed.

Policy Amplification:

1. All correspondence pertinent to the function of the House of Delegates shall be sent to the Speaker of the House of Delegates.
 - A. The Speaker shall cause correspondence to be distributed appropriately to members of the House of Delegates.
2. All HOD Officers shall receive correspondence directed to the BOD and Board agenda books as approved by the President.
3. Newly elected House Officers shall receive a copy of the Association's Policy and Procedure Manual.

DEFINITIONS:

ATTACHMENTS: AARC Conflict of Interest Statement (See Appendix)

American Association for Respiratory Care Policy Statement

Page 1 of 1
Policy No.: HOD.002

SECTION: House of Delegates

SUBJECT: **Procedures – Rules**

EFFECTIVE DATE: June 18, 2002

DATE REVIEWED:

DATE REVISED:

REFERENCES: Delegate Handbook

Policy Statement:

All procedural activities of the House of Delegates can be found in the Delegate Handbook and House Rules.

Policy Amplification:

Any information regarding the procedural activities of the House of Delegates, from committees to resolutions, can be found in the Delegate Handbook. The Delegate Handbook also contains the House Rules under which the House of Delegates operates.

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care Policy Statement

Page 1 of 2
Policy No.: MP.001

SECTION: Membership
SUBJECT: **General Operating Policies**
EFFECTIVE DATE: December 14, 1999
DATE REVIEWED:
DATE REVISED:

REFERENCES: Bylaws, Code of Ethics, House Rules for Special Recognition

Policy Statement:

The Association's membership shall be subject to the provisions of Association Bylaws and Association policy.

Policy Amplification:

1. All personal records of Association members shall be the property of the Association and shall be held in strict confidence.
2. Members whose AARC membership has lapsed may reactivate their membership in the Association by payment of the current year's membership dues plus the fee set in the Annual Budget subject to the following conditions:
 - A. The lapse in membership has been for a maximum time period of one year.
 - B. The member must meet current Bylaws requirements for appropriate membership classification
3. AARC members shall be granted reciprocity of chartered affiliate membership without inter-affiliate transfer of current chartered affiliate dues paid.
4. All new and renewing members shall be required to complete the AARC membership application and subsequent renewal cards in their entirety.

5. The Membership Committee shall assure that a request for medical direction, when applicable, be included on the membership application.

American Association for Respiratory Care Policy Statement

Page 2 of 2
Policy No.: MP.001

6. All AARC Members with twenty (20) or more years of continuous membership shall receive a letter of congratulations and thanks from the President and Executive Director.
7. All nominations for Life Membership submitted to the House of Delegates by a delegation shall include curriculum vitae as justification, and a resolution recommending such action shall be submitted to the House at least sixty (60) days prior to the Annual Meeting of the Association.
8. Life Membership shall automatically be bestowed upon an AARC President upon completion of his/her term as Immediate Past-president.
9. All Active and Life Members of the Association employed within the boundaries of chartered affiliates shall be permitted to vote in the election of the delegation of that affiliate, regardless of their separate affiliate membership status.
10. That students enrolled in an accredited respiratory therapy education program be permitted to join AARC as student members at no charge with the following qualifications:
 - a. Access to *AARC Times* and *RESPIRATORY CARE* will be limited to the internet.
 - b. That 100% of the faculty in the program where the student is enrolled be either an active or associate member of AARC.”

DEFINITIONS:

ATTACHMENTS:

American Association for Respiratory Care Policy Statement

Page 1 of 1
Policy No.: CT.002

SECTION: Committees

SUBJECT: **Medical Advisors**

EFFECTIVE DATE: December 14, 1999

DATE REVIEWED:

DATE REVISED: **March, 2009**

REFERENCES:

Policy Statement:

Committees shall have Medical Advisors as requested by the President, identified by the Chair of the Board of Medical Advisors (BOMA) and appointed by the President.

Policy Amplification:

1. Special Committees and other groups shall have Medical Advisors as determined by the President.
 - A. BOMA shall submit names for Committee Medical Advisors to the President for appointment and ratification by the Board of Directors.

DEFINITIONS:

ATTACHMENTS: