

**Focused Course Reporting Template for CASE Committee Approval**

Accreditors must copy this report to the Education Provider so that they can address conditions and comment on recommendations prior to seeking CASE Committee approval.

**Please complete a separate report for each Focused Course.**

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| Name of Education Provider |  |
| Name of Division/Department/School  |  |
| Date of (Re) accreditation event |  |
| Date of completion of (Re) accreditation process\* |  |
| Lead Accreditor for CASE |  |
| Co-accreditor for CASE |  |
| Shadow Accreditor for CASE |  |
| Accreditors’ recommendation | Approve accreditation |  | Defer accreditation (further information needed) |  |

\*Date of accreditation will commence following approval by the CASE Committee.

 Committee meeting dates can be found at: [Meeting Dates (case-uk.org)](http://www.case-uk.org/for-heis/case-meeting-dates/)

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| **Title of Focused Ultrasound Course** | **Number** **of Credits** | **Academic Level** |
|  |  |  |
| **Scope of Focused Course Accreditation** | **Virtual****Only** | **Visit****Required** |
| Accreditation of new Focused Ultrasound Course |  |  |
| Re-accreditation of existing Focused Ultrasound Course |  |  |
| Minor change to existing Focused Ultrasound Course |  |  |
| Major change to existing Focused Ultrasound Course |  |  |

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| **Focused Ultrasound Course Director/Lead** |
| Name |  |
| Address |  |
| Telephone |  |
| E-mail |  |

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| **Representative in the University Quality & Standards Office** |
| Name |  |
| Address |  |
| Telephone |  |
| E-mail |  |

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| **Name & Job Title of Panel Members attending Validation/Re-validation Event** |
| Chair |  |
| Quality Officer |  |
| External Panel Member |  |
| Internal Panel Members |  |
| CASE Lead Accreditor |  |
| CASE Co-accreditor |  |
| **Name & Job Titles of Programme Team at the Validation/Re-validation Event** |
|   | Focused Ultrasound Course Director/Lead |
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| **Summary of Main (Re) accreditation Meeting, Subsidiary Meetings & Issues** |
| *Subsidiary meetings include those with the Course Team, student representatives, clinical mentors/assessors and service providers.* *A summary of the main issues raised in each meeting should be included.* |

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| **Summary of Facilities and Resources Reviewed/Inspected** |
| *Facilities and resources include the Library, IT facilities, virtual learning environment (VLE), student support, clinical placements, and specialist learning and teaching resources such as simulation suites.* *A summary of the facilities and resources reviewed/inspected should be included, along with any key issues raised.* |

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| **Identify Specific Concerns Regarding Course Content, Delivery or Assessment for Future Review** |
| *Note any concerns which cannot be made a condition (eg. staff to student ratio) but which should be picked up again by the APMR process and/or an interim review.* |

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| **Commendations regarding the Accreditation/Re-accreditation** |
| **1** |  |
| **2** |  |
| **3** |  |
| **4** |  |
| **5** |  |

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| **Recommendations regarding the Accreditation/Re-accreditation** |
| **1** |  |
| **2** |  |
| **3** |  |
| **4** |  |
| **5** |  |

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| **Conditions to the Accreditation/Re-accreditation** |
| **1** |  |
| **2** |  |
| **3** |  |
| **4** |  |
| **5** |  |

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| **Date by which Conditions are to be met:**  |  |

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| --- | --- | --- |
| **Have the Conditions now been met?**  |  **YES** |  **NO**  |

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| --- | --- | --- |
| **Do you recommend (Re) accreditation?**  |  **YES** |  **NO**  |

|  |  |
| --- | --- |
| **Recommended period of (Re) accreditation:**  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Lead Accreditor:** |  | **Date:** |  |
| **Signature of Lead Accreditor:** |  |

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| --- | --- | --- | --- |
| **Name of Co-accreditor:** |  | **Date:** |  |
| **Signature of Co-accreditor:** |  |

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| **FOR OFFICE USE ONLY** |
| **Date Accreditation/Re-accreditation Approved by CASE Committee:** |  |
| **Date of Receipt of Final Documentation at CASE Office:** |  |