**PROPOSAL SUMMARY AND ROUTING FORM**

**Proposal Title:** Delete Medical Office Assistant Certificate program

**Initiating Unit or Individual:** Health Information Technology/Management programs  
**Contact Person’s Name:** Paula Hagstrom  
**e-mail:** hagstrom@ferris.edu  
**phone:** 591-2316

**Date or Term of Proposal Implementation:**

- Group I - A – New degree/major or major, redirection of a current offering, or elimination of a degree, major or minor
- Group I - B – New minors or concentrations
- Group II - A – Minor curriculum clean-up and course changes
- Group II - B – New Course
- X Group III - Certificates
- Group IV – Off-Campus Programs

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<tr>
<th>Group/Individual</th>
<th>Signature</th>
<th>Date</th>
<th>Vote/Action *</th>
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<tr>
<td>Program Faculty</td>
<td>Paula Hagstrom</td>
<td>3/10/10</td>
<td>☑ Support</td>
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<tr>
<td>Department Faculty</td>
<td>M. Sickelsled</td>
<td>3/16/10</td>
<td>☑ Support with Concerns</td>
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<td>Department Head</td>
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<td>College Curriculum Committee</td>
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<td>College Faculty</td>
<td>Allen Haneline</td>
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<td>Academic Affairs</td>
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* *Support with Concerns or Not Support must include a list of specific concerns. Votes must be shown for faculty groups. Administrators check appropriate action taken.*

**To be completed by Academic Affairs**

<table>
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<tr>
<th>President (Date Approved)</th>
<th>Board of Trustees (Date Approved)</th>
<th>President’s Council (Date Approved)</th>
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1. **Proposal Summary**

   There has not been enough interest in the Medical Office Assistant Certificate program to warrant offering it. We have not had any students enroll in this program. The certificate was developed for displaced workers. Many displaced workers chose the Health Information Technology program because it is an associate degree program that can be completed in two years and students are able to begin the program fall, spring, or summer semesters. Most medical office assistant positions require only a high school diploma.

2. **Summary of All Course Action Required**

   a. Newly Created Courses to FSU:
      
      Prefix   Number   Title

   b. Courses to be Deleted From FSU Catalog:
      
      Prefix   Number   Title
      MRIS     104      Introduction to Medical Office
      MRIS     192      Professional Practice

   c. Existing Course(s) to be Modified:
      
      Prefix   Number   Title

   d. Addition of existing FSU courses to program
      
      Prefix   Number   Title

   e. Removal of existing FSU courses from program
      
      Prefix   Number   Title
3. Summary of All Consultations

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<th>Form Sent (B or C)</th>
<th>Date Sent</th>
<th>Responding Dept.</th>
<th>Date Received &amp; by Whom</th>
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4. Will External Accreditation be Sought? (For new programs or certificates only)

__________ Yes __________ No

If yes, name the organization involved with accreditation for this program.

5. Program Checksheets affected by this proposal.
I. ACTION TO BE TAKEN: DELETE COURSE FROM CATALOG.

Note: Complete each section.

The course described below will be moved to inactive status.

a. Term Effective: Term Summer Year 2010 See instructions.

II. CURRENT COURSE TO BE DELETED FROM THE ACTIVE STATUS:

Include the information that is in the current course database.

a. Course Prefix b. Number c. Enter Contact Hours per week in boxes.
MRIS 104 LECTure 2 LAB 2  INDependent Study – Check (x) 
Practicum: Seminar: 

d. Full Course Title: Introduction to Medical Office
I. ACTION TO BE TAKEN: DELETE COURSE FROM CATALOG.

Note: Complete each section.

The course described below will be moved to inactive status.

a. Term Effective: Term Summer Year 2010 See instructions.

II. CURRENT COURSE TO BE DELETED FROM THE ACTIVE STATUS:

Include the information that is in the current course database.

a. Course Prefix b. Number c. Enter Contact Hours per week in boxes.
MRIS 192 LECTure [ ] LAB [ ] INDependent Study – Check (x) [ ]
Practicum: 40 Seminar: [ ]

d. Full Course Title: Professional Practice

UCC Chair Signature/Date: _________________________ /___/

Academic Affairs Approval Signature/Date: _________________________ /___/

Office of the Registrar use ONLY
Date Rec’d: _____ Date Completed: _____ Entered: SCACRSE ___ SCADETL ___ SCARRES ___ SCAPREQ ___