Accreditation Program Application Request Form

For laboratories/facilities seeking accreditation for multiple accreditation programs and/or laboratory sites, Clinical Laboratory Improvement Amendments (CLIA) numbers, satellite, clinic, or special-function laboratories, please reproduce this form and submit a separate *Application Request Form* and fee for each laboratory/facility or each accreditation program.

Please make your program selection (required) Claboratory Accreditation Program (General - LAP)	Laboratories interested in the CAP15189 Accreditation Program must complete LAP accreditation first. For information about														
Reproductive Laboratory Accreditation Program (RLAP) Forensic Drug Testing Accreditation Program (FDT)	preparing for CAP15189 Program contact CAP15189@cap.org. Patient Testing														
O Biorepository Accreditation Program (BAP)															
CAP Number	Has patient testing started Yes No														
CAP Number (if available)	If "No" provide anticipated start date														
CLIA Number	Month Day Year														
CLIA Number (if available)	Domestic*														
	Is the laboratory requesting this application enrolled in CAP Proficiency														
Who currently accredits or certifies your laboratory?	Testing Program(s)?														
The carrotting accreate of continue your laboratory.	○ Yes ○ No ○ N/A (for BAP only)														
Miles Coding a constitution of the code of	International not subject to US (CLIA) regulations** Has your laboratory been enrolled in CAP Proficiency Testing Program														
What is the accredition end date	for at least 6 months? (Do not continue with this request if "No" was														
	answered. Contact the CAP for assistance.) ○ Yes ○ No														
Month Day Year	* Includes US, Canada, Puerto Rico, and Guam														
Laboratory/Facility Information (required)	** Does not include Canada, Puerto Rico, and Guam														
Hospital or Institution Name															
Laboraton/Escility Nama															
Laboratory/Facility Name															
Physical Address/Street Address															
City	State Postal Code														
Province (Use abbreviation) Country															
Townie (Ge abbewator) County															
Phone Country Code Area Code Laboratory/Facility Phone	Extension Area Code Laboratory/Facility Fax														
Laboratory /Facility Contacts (required)															
Laboratory/Facility Director															
First Name Last Name	O MD O DO O PhD														
	Other														
Laboratory Director E-mail Address															
Primary Contact Person (required)															
Primary Contact Person (required) First Name Last Name															
Contact E-mail Address															

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Payment Information

A nonrefundable application fee of \$1200 (domestic*) and \$1500 (international**) is required per laboratory/facility to initiate the application process. The application fee may be waived if CAP accreditation checklists have been purchased within the past six months.

If you are applying for multiple accreditation programs and/or multiple CLIA numbers, satellites, clinics, or special-functions laboratories, please submit a separate Application Request Form and fee for each program or site being accredited.

Total Payment \$	
Payment Options (c	choose one):
○ Check	Check Number
O Credit Card	Card Number Expiration Date
	Print Cardholder's Name ☑
	Cardholder's Signature * Includes US, Canada, Puerto Rico, and Guam ** Does not include Canada, Puerto Rico, and Guam
O Wire Transfer	Include Institution Name and state; "Accreditation Application fee" when remitting payment. Please include all bank fees with your payment. Notify the CAP at arcap@cap.org upon completion of the transfer.
	Remit wire transfer payment to: BMO Harris Bank 111 West Monroe Street Chicago, IL 60606, USA Phone: 312-461-2121
	ABA Number: 071000288 Account Number: 2237337 SWIFT#:HATRUS44
O Accreditation Ch	necklist has been purchased
	Order #
Submit this Form	by one of these methods:

If payment method is credit card or wire transfer, email form to Customer Data Management (CDM) at:

Email: cdm@cap.org

If you are submitting your payment by check please mail the form and check to:

College of American Pathologists 325 Waukegan Road Northfield, IL 60093-2750

For more information, please call the CAP at 1-800-323-4040, option 1 (domestic), or 847-832-7000 (Country code 001), option 1 for international.



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