## **Accreditation Program Application Request Form**

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

Please make your program selection				CAP N	lumber	CLIA Number	CLIA Number		
					r (if available)	CLIA Number (if available)			
○ Reproductive	e Laboratory	Accreditation	Program (RLAP)			D			
<ul> <li>Forensic Dru</li> <li>Biorepository</li> </ul>									
Domestic*		on i iografii (B			International sub	iect to CLIA**			
	ratory reque	esting this and	ication enrolled in	CAP		atory been enrolled in a CAP-accepted			
	y Testing Pro			CAI		sting Program for at least 6 months?			
$\bigcirc$ Yes	○ <b>No</b> ○	N/A (for BAP of	only)			o (Do not continue with this request if "No" was			
2. Who curre	antly accredit	te or cortifice v	our laboratory?		2 Who currently	answered. Contact the CAP for assistance.) provides your proficiency testing materials?			
2. Who curre		is of certifies y	our laboratory !		2. Who currently	provides your proficiency testing materials?			
					International net	subject to US (CLIA) regulations			
						subject to US (CLIA) regulations y been enrolled in CAP Proficiency			
					Testing Program for	or at least 6 months?			
		o Rico, and Gua			⊖Yes ⊖No (	Do not continue with this request if "No" was			
	,	Puerto Rico, an			e e e e e e e e e e e e e e e e e e e	answered. Contact the CAP for assistance.)			
Laboratory/Fa Hospital or Institution Na		nation (requi	ea)						
Laboratory/Facility Nam	e								
Physical Address/Street	Address								
City					State	Zip Code			
Province (Use abbreviat	tion)	Country							
Phone									
Country Code	Area Code	Laboratory	/Facility Phone	<u>E</u>	xtension	Area Code Laboratory/Facility Fax			
		_							
Laboratory /Fa	acility Cont	acts (required	)		· · · · ·				
Laboratory/Facility Direc			Laboratory/Facility Directo	or (Last Name)		() MD () DO () Ph	D		
						○			
Laboratory Director E-m	ail Address						_		
Primary Contact Perso First Name	n		LastName						
Contact E-mail Address									
Alternate Contact Person (required)									
First Name	· · ·		Last Name				1		
Contact E-mail Address									





	(required for Accreditation related packages)	
hipping Address		
ty	State	Zip Code
ovince (Use abbreviation)		
lailing Addross (	equired for Accreditation related envelopes)	
ailing Address (I	equired for Accreditation related envelopes;	
ty	State	Zip Code
ovince (Use abbreviation)	Country	
Payment Informa	tion	Submit this Form by one of these methods
	application fee of \$1150 (domestic*) and \$1450 (international) is atory/facility to initiate the application process.	If method is credit card or wire transfer emai or fax form.
lf vou are applvin	g for multiple accreditation programs, CLIA numbers, satellites, clinics,	
or special-functio	ns laboratories, please submit a separate Application Request Form	Email: cdm@cap.org
and fee for each	program being accredited.	Fax: 847-832-8168
		1 47. 047 002 0100
Total Payment	\$	If you are submitting your payment by check
		please mail the form and check to:
Payment Option	S	Customer Data Management
(choose one):		College of American Pathologists
	Check Number	325 Waukegan Road
Check		Northfield, IL 60093-2750
		For more information places call the CAD at
	Card Number	For more information, please call the CAP at 1-800-323-4040, option 1, or 1-847-832-7000
○ Credit Card		
		· • • • •
		COLLEGE of AMERICAN
		PATHOLOGISTS
	Print Cardholder's Name 🗵	
	Cardholder's	_
	Signature 🖾	-
	Wire Transfer: Include Institution Name and states "Appreditation Application for	
○ WireTransfer	Wire Transfer: Include Institution Name and state; "Accreditation Application fe 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	
	311 West Monroe Street	
	Chicago, IL 60606, USA	
	Phone: 312-461-2121 ABA Number071000288 SW/JET#HATPUS44	
	ABA Number071000288 SWIFT#HATRUS44	

