**Accreditation Application Form**

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| Name of *Program* to be accredited: |  |
| Name of *department or unit*  in which the Program is housed: |  |
| Name of *college, school or division* in which department or unit is housed: |  |
| Name of *institution* in which the  college, school or division is housed: |  |
| Institution accredited by: |  |
| Next institutional reaccreditation date: |  |
| Name of Program Director: |  |
| Program mailing address: |  |
| Telephone: |  |
|  |
|  |
| Fax (if available): |  |
| Email: |  |

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| Is the Program Director a full time faculty member in the department or unit in which the Program is housed? | Yes  ☐ | No  ☐ |
| Does the department or unit in which the Program is housed have at least two full time faculty? | Yes  ☐ | No  ☐ |
| Does the Program require a practice experience for its students (e.g., practicum, internship, or fieldwork)? | Yes  ☐ | No  ☐ |
| Has the Program been in existence and/or operational for two years? | Yes  ☐ | No  ☐ |
| Number of students currently enrolled  in the program: |  | |
| Number of students completing the program in the last two years: |  | |
|  |  | |
| Name of degree(s) received by  students graduating: |  | |
|  | |
|  | |
| CAPACS Accreditation standards  have been reviewed: | Yes  ☐ | No  ☐ |

**Please submit with the application**:

* Two (2) copies of the program description from institution’s catalogue and/or published brochure describing the Program. *The documents may be printed and/or digital or published on the website (provide URLs or embedded links).*
* Application Fee of $100 USD payable to the Commission on the Accreditation of Programs in Applied and Clinical Sociology.

**Please certify and sign as indicated below.**

**I certify that all information provided on this form is accurate to the best of my knowledge.**

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| Program Director Date |  | Department or Unit Chair Date |
|  |  |  |
| Dean/Academic Director Date |  | Chief Academic Officer Date |