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)

- ◯ Laboratory Accreditation Program (General - LAP)
- ◯ Reproductive Laboratory Accreditation Program (RLAP)
- ◯ Forensic Drug Testing Accreditation Program (FDT)
- ◯ Biorepository Accreditation Program (BAP)

CAP Number

CAP Number (if available)

CLIA Number

CLIA Number (if available)

D

Who currently accredits or certifies your laboratory?

What is the accredition end date

Month / Day / Year

Laboratories interested in the CAP15189 Accreditation Program must complete LAP accreditation first. For information about preparing for CAP15189 Program contact CAP15189@cap.org.

Patient Testing

Has patient testing started

◯ Yes ◯ No

If **"No"** provide anticipated start date

Month / Day / Year

Domestic*

Is the laboratory requesting this application enrolled in CAP Proficiency Testing Program(s)?

◯ Yes ◯ No ◯ N/A (for BAP only)

International not subject to US (CLIA) regulations**

Has your laboratory been enrolled in CAP Proficiency Testing Program for at least 6 months? (Do not continue with this request if **"No"** was answered. Contact the CAP for assistance.)

◯ Yes ◯ No

** Includes US, Canada, Puerto Rico, and Guam*

*** Does **not** include Canada, Puerto Rico, and Guam*

Laboratory/Facility Information (required)

Hospital or Institution Name

Laboratory/Facility Name

Physical Address/Street Address

City

State

Postal Code

Province (Use abbreviation)

Country

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

◯ MD ◯ DO ◯ PhD

◯ Other _____

Laboratory Director E-mail Address

Primary Contact Person (required)

First Name

Last Name

Contact E-mail Address

62445

2020-15846
July2020

Shipping Address (required for Accreditation related packages)

◯ Same as physicial ◯ Same as Billing address
◯ Same as Mailing address

Shipping Address

City

State

Postal Code

Province (Use abbreviation)

Country

Mailing Address (required for Accreditation related envelopes)

◯ Same as physicial ◯ Same as Billing address
◯ Same as Mailing address

Mailing Address

City

State

Postal Code

Province (Use abbreviation)

Country

Billing Contact and Address

Billing Contact (required)

First Name

Last Name

E-mail Address (required)

Address

City

State

Postal Code

Province (Use abbreviation)

Country

8273

2020-15846
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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 (choose one):

○ Check

Check Number

○ Credit Card

Card Number

Expiration Date ___ / ___

Print Cardholder's Name ☒ _____

Cardholder's Signature ☒ _____

**Includes US, Canada, Puerto Rico, and Guam*

○ Wire Transfer

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
311 West Monroe Street
Chicago, IL 60606, USA
Phone: 312-461-2121
ABA Number071000288 SWIFT#HATRUS44

○ Accreditation Checklist has been purchased

Order # _____

Submit this Form by one of these methods:

If payment method is credit card or wire transfer, email form.

Email: cdm@cap.org

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

Customer Data Management
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 001-847-832-7000 option 1 (international).

COLLEGE of AMERICAN PATHOLOGISTS

4299

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