Graphical user interface, text, application

Description automatically generated

CCAPS APPLICATON

|  |  |
| --- | --- |
| Name and Address of Organization |  |
| Requesting: | 1. Assessment and Evaluation 2. CCAPS accreditation 3. Periodic Review for continued CCAPS accreditation |
| Name, title, telephone, and email of contact person |  |
| Director of Chaplaincy contact information |  |
| Date of last site visit (If applicable) |  |
| Date Accreditation Expires (if applicable) |  |
| Preferred time for site visit or consultation | Month or Season ((Fall, Winter, Spring, Summer) |
| Name of CEO/Administrator: | Signature  Date: |
| Name of Chaplaincy Direct Report (If not CEO/Administrator) | Signature  Date |
| Name of Director of Chaplaincy Services: | Signature  Date: |

Return via email to: Russell H. Davis, PhD, CCAPS Chair at russell.haden.davis@gmail.com.