

CCAPS APPLICATON

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| Name and Address of Organization |  |
| Requesting:  | 1. Assessment and Evaluation
2. CCAPS accreditation
3. Periodic Review for continued CCAPS accreditation
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| 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: | SignatureDate: |
| Name of Chaplaincy Direct Report (If not CEO/Administrator) | SignatureDate |
| Name of Director of Chaplaincy Services: | SignatureDate: |

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