

**CANADIAN ATHLETIC THERAPISTS ASSOCIATION
PROGRAM ACCREDITATION COMMITTEE**

APPLICATION FOR INITIAL ACCREDITATION

Signed by the President of the sponsoring institution or the delegated representative, this application is a request that the Canadian Athletic Therapists Association's Program Accreditation Committee begin the process of accreditation review of the applicant program.

The accreditation process is initiated only at the request of the institution sponsoring the Athletic Therapy program. The process provides peer review of the program's educational content, policies, and procedures. It is a review based on recognized national education standards, called *Standards*. The Canadian Athletic Therapists Association has adopted the Standards.

The Canadian Athletic Therapists Association (CATA) levies each institution sponsoring an Athletic Therapy program an annual program fee of \$750.00. The President of the institution or delegated representative will receive the notice requesting payment annually from the CATA. (Payment of the annual program fee is not due with this application; however, the application fee of \$500.00 is.)

PLEASE TYPE OR PRINT INFORMATION CAREFULLY

Name of Sponsoring Institution

SPONSORING INSTITUTION'S OFFICIALS

President	Degree/Credentials	Date
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Signature	Date
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Mailing Address

City, Province, Postal Code	Area Code and Telephone No.
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Dean or Comparable Administrator	Degree/Credentials	Date
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Signature	Date
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Mailing Address

City, Province, Postal Code	Area Code and Telephone No.
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PROGRAM INFORMATION

Name of Profession _____

Name of Program _____

Mailing Address (if different from sponsoring institution's address)

City, Province, Postal Code

Area Code and Telephone No.

PROGRAM OFFICIALS

Program Director

Degree/Credentials

Area Code & Telephone Number

Medical Director/Advisor (if applicable)

Degree/Credentials

Area Code & Telephone Number

Length of Program (in months) _____

Months classes begin _____

Award Granted _____
(Specify – BA, BSc, BKin, etc)

Average 1st year tuition for full-time students:
resident _____ non-resident _____

Maximum enrollment capacity (first year students) _____

Month and year program first accepted, or tends to accept, students:

Month

Year

List academic or clinical affiliates on separate sheet

Return this completed application to:
Chair, CATA Program Accreditation Committee
c/o CATA
Suite 402 - 1040 7th Avenue S.W.
Calgary, AB, T2P 3G9