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Description automatically generated

**Intent to Apply for Institutional Accreditation**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Sponsoring Institution**  *(The entity that has ultimate responsibility for ACGME-accredited programs)* | | | | | | | | |
| **Name of Sponsoring Institution**: | | | | | | | | |
| **Address**: | | | | | | | | |
| **City, State, ZIP code**: | | | | | | | | |
| **Sponsor Website Address**: | | | | | | | | |
| **Designated Institutional Official (DIO) Information**  *(The individual who has the authority and responsibility for all of the ACGME-accredited graduate medical education programs at this institution)* | | | | | | | | |
| **Salutation**: | **First Name**: | | **Middle**: | | **Last**: | | | |
| **Degree(s)**: | | | | **Email**: | | | | |
| **Mailing Address**: | | | | **Phone**: | | | | |
| **Fax**: | | | | |
| **Ownership/Control and Type of Institution**  (*Address the type of institution being applied for as well as the specifics of its oversight*) | | | | | | | | |
| **Ownership or Control Type** (*select one*):  *See* [*Data Dictionary for Sponsoring Institution and Participating Site Ownership/Control Types*](https://acgmehelp.acgme.org/hc/en-us/articles/14071500332567-Data-Dictionary-for-Sponsoring-Institution-and-Participating-Site-Ownership-Control-Types) *for definitions* | | | | | | | | |
| Government, Federal: | | | Government, Tribal | | | | | |
| Government, Non-Federal: | | | Non-Government, Not-for-Profit: | | | | | |
| Investor-Owned, For-Profit: | | | Physician-Owned, Not Incorporated | | | | | |
| **Type of Institution** (*select one*):  *See* [*Data Dictionary for Sponsoring Institution and Participating Site Types*](https://acgmehelp.acgme.org/hc/en-us/articles/14071444045079-Data-Dictionary-for-Sponsoring-Institution-and-Participating-Site-Types) *for definitions* | | | | | | | | |
| Ambulatory Care/Community Health Center | | Ambulatory Care/Other:  *If Other, please specify:* | | | | Ambulatory Surgery Center | | |
| Consortium | | End-of-Life Care Facility (Hospice) | | | | General Hospital | | |
| Governmental Public Health Agency | | Health System | | | | Long-Term Care Facility | | |
| Medical Examiner’s Office | | Medical School | | | | Military Treatment Facility: | | |
| Non-Medical School Educational Foundation/Organization | | Poison Control Center | | | | Prison/Jail/Other Carceral Facility | | |
| School (Primary/Secondary/College/University) | | School of Public Health | | | | Specialty Hospital:  *If Other, please specify:* | | |
| Sports Venue | | VA Healthcare System Facility: | | | | Blood Collection and Processing Center | | |
| Reference Laboratory | | Other (please specify): | | | | | | |
|  | | | | | | | | |
| For how many programs does the Sponsoring Institution plan to apply for accreditation? | | | | | | |  | |
|  | | | | | | | |  |
| **I recognize this form is not an application for ACGME institutional accreditation, but a means to indicate intent to begin the application process for institutional accreditation.**  DIO Signature: Date: | | | | | | | | |

Email this completed form to [ADS@acgme.org](mailto:ADS@acgme.org). Once it has been received and processed, the DIO will be emailed a username and password to access the Accreditation Data System (ADS) to complete the application for institutional accreditation.