



ACCREDITATION APPLICATION

Agency Name _____

Agency Address _____

_____ Zip _____

Agency Chief Executive _____ Title _____

Tel. No. _____ Fax No. _____

E-mail _____ No. of FTEs* _____

Our department is:

- IACLEA Member
- Not an IACLEA Member

For the Agency:

Authorized Institutional Representative:

(Signature)

(Signature)

(Title)

(Title)

(Date)

(Date)

Please return the completed application, along with the \$150.00 application fee, to IACLEA, 342 North Main Street, West Hartford, CT 06117-2507

**FTE – Full-Time Equivalent enrollment, as calculated in the most recent listing of the U.S. Department of Education’s Integrated Postsecondary Education Data System (IPEDS).*