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**CLINICAL INTERNSHIP ACCREDITATION  
Intent to Apply Form**

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| Name of Clinical Internship: |
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| --- | --- | --- |
| Primary Contact Person Name: | Title: | |
|  |  | |
| Mailing Address: | Preferred Phone: |  |
|  | Pager: |  |
| Fax: |  |
| Email address: |  |

|  |  |  |
| --- | --- | --- |
| Secondary Contact Person Name: | Title: | |
|  |  | |
| Mailing Address: | Preferred Phone: |  |
|  | Pager: |  |
| Fax: |  |
| Email address: |  |

**Statement of Understanding**

* I attest that the information on this form is true and accurate to the best of my knowledge.
* I understand that this Clinical Internship is expected to be prepared to submit an application for accreditation, with accompanying application fee of $1500.00.
* I understand if application materials and/or payment are received more than 3 weeks after the application deadline, the Internship Accreditation Oversight Committee cannot guarantee review in the assigned quarter. Application materials and payment will be held and reviewed as soon as possible, based on reviewer workload and availability.
* I understand that Clinical Internships receiving accreditation during the initial 5 year period (“early”) may be asked to have a statement on their website or on their Clinical Internship’s listing on the ACLP Program Directory indicating that early accreditation does not indicate a higher quality clinical internship than those who have not yet had the opportunity to apply or have their application reviewed.

Primary Contact Signature:

Date:   
  
Please fax to 571-483-4482 or scan/email to [InternshipAccreditation@childlife.org](mailto:InternshipAccreditation@childlife.org)