



NATIONAL ENVIRONMENTAL HEALTH SCIENCE & PROTECTION ACCREDITATION COUNCIL (EHAC)

Intent to Reaccredit Form

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|---|-------------|-----------|
| Program Name: | | Date: |
| Institution Name: | | |
| Undergraduate or Graduate Program (If you have both an undergraduate and graduate program reaccrediting in the same year, please note that below (Please also note: there is a \$500 reaccreditation fee for each program): | | |
| Name of Program Administrator*: | | |
| Name of Program Director**: | | |
| Program Contact Director E-mail address: | | |
| Mailing Address: | | |
| City: | State: | Zip Code: |
| Telephone number: | Fax number: | |

* The Program Administrator is person responsible for administration of the program seeking accreditation.

** The Program Director listed above will receive all official communication from the National Environmental Health Science and Protection Accreditation Council (EHAC).

A reaccreditation fee of \$500.00 will be invoiced to your program(s) upon receipt of this form. Please submit this form to Leslie Mitchel at ehacinfo.aehap.org by September 29, 2017.

By signing below, the program(s) listed above affirms the intent to seek reaccreditation with the National Environmental Health Science & Protection Accreditation Council (EHAC).

Signature of Program Administrator

Date

FOR OFFICE USE ONLY

| | | | |
|------------------|----------|----------------|--|
| Application Fee: | \$500.00 | Date Received: | |
|------------------|----------|----------------|--|

The National Environmental Health Science & Protection Accreditation Council (EHAC)
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