The Association of Technology, Management, and Applied Engineering

ATMAE
LEAD • INNOVATE • COLLABORATE

Request for Initial Visit, Reaccreditation Visit or Report & Visit

Please Type Information

1. **Institution** ______________________________
   Institution Address ______________________________
2. **Head of Institution** ____________________ Title ____________
   Telephone ____________________ Fax ____________
3. **Head of Program** ____________________ Title ____________
   Telephone ____________________ Fax ____________
4. **Contact Person** ____________________ Title ____________
   Mailing Address ______________________________
   Telephone ____________________ Fax ____________
   Email Address ______________________________

5. **Type of Visit Requested (All Visits starting in 2013 will use the Outcomes Assessment Model):**
   [ ] Initial Accreditation [ ] Reaccreditation [ ] 2-Year Follow-Up

6. **Program Level:** [ ] Associate [ ] Baccalaureate [ ] Master

7. **List Technology Program(s) (including options, concentrations, and specializations) to be considered** (Note: All options, specializations, and concentrations in a degree program MUST be reviewed. Except as noted in PA.2 Program Definition: of the Outcomes Assessment Model).

Degree	Program Name	Option, Concentration, or Specialization	CIP Code

(Attach additional sheet if necessary)

8. **Billing Address:**
   ____
   ____

9. **Regional Accrediting Agency:** ______________________________

10. **Proposed Dates for Visit** (Note: a minimum of two full days are required for the visit plus a travel day).
    First Choice: ____________________ Second Choice: ____________________

11. **Recommended Team Member Lodging** (include name, address, and telephone number).
    If your school has a discounted hotel rate, may ATMAE use it during the visit: Yes___ No ___
    ____
    ____

12. **Authorized Signatures:**
    Institution Contact Person: ____________________ Date: ____________
    Head of Program: ____________________ Date: ____________
    Head of Institution: ____________________ Date: ____________

Please return this form to ATMAE Accreditation Director, 3801 Lake Boone Trail, Ste 190, Raleigh, NC 27607
Email Accreditation@atmae.org
Phone (919) 635-8335 Fax (919) 779-5642