



200 West Baltimore Street, Baltimore, MD 21201 FAX: 410-333-6226

THE EARLY CHILDHOOD ACCREDITATION/VALIDATION APPLICATION

Name of Organization _____	Supervisor _____
Name of Program/School _____	Support person (if applicable) _____
Address _____	Telephone _____
_____	Fax _____
County _____	Hours of operation _____ a.m to _____ p.m.

Self-Appraisal Team Members

Name	Position	Name	Position
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(use additional paper if necessary)

Established timeline to complete accreditation

Date (Month/Year)	Date (Month/Year)
Orientation for staff _____	Complete Self-appraisal _____
Pre-validation visit _____ (if applicable)	Projected Validation visit _____
Name of person completing this form _____	Position: _____ Date _____

The date of the application receipt at MSDE is the determining date of initiation of the self-appraisal process.

Mail or fax a copy of the program's current Office of Child Care License and/or MSDE Non Public School Approval Certification with this application (if applicable) to MSDE, Early Childhood Accreditation Project. (address above)

For MSDE Use:
Date Rec'd: _____