Commission on Cancer®

A QUALITY PROGRAM of the AMERICAN COLLEGE OF SURGEONS

Please provide all the information requested. When complete, please save the PDF with your facility s name, city, and state in the document title. Please send the complete application to Susan Rubin at srubin@facs.org .

Commission on Cancer
Application for Accreditation

Facility Identification and Program Contacts

Facility Name:

Address:

City: Facility State: Facility Zip:

Web Address:

Current Annual Case Load: Category: Comprehensive Community Canc

CEO, Dean or Equivalent

Name: Credentials:

Title:

Facility Name:

Address:

City State: Zip:

Email: Telephone number:

Cancer Program Administrator

Name: Credentials:

Title:

Facility Name:

Address:

City State: Zip:

Email: Telephone number:

Cancer Committee Chair

Name: Credentials: Specialty

Title:

Facility Name:

Address:

City: State: Zip:

Email: Telephone number:

Cancer Liaison Physician

Name: Credentials: Specialty

Title:

Facility Name:

Address:

City State: Zip:

Email: Telephone number:

Cancer Registrar

Name: Credentials:

Title:

Facility Name:

Address:

City State: Zip:

Email: Telephone number:

Primary Contact Person (select one)

- ◯ Cancer Program Administrator
- ◯ Cancer Committee Chair
- ◯ Cancer Liaison Physician
- ◯ Other (please provide contact information below:

Name: Credentials:

Title:

Facility Name:

Address:

City State: Zip:

Email: Telephone Number:

General Facility Information

Industry Accreditation: The Joint Commission

Facility Type: 01 Pathology Lab

Ownership 12 State

Facility FEIN:

Facility NPI

Facility Re-Application - Defined as a facility that previously applied or was previously accredited.

- Facility withdrew as CoC-accredited cancer program
- CoC denied accreditation
- Facility lost accreditation
- Facility withdrew application

Registry Information

How long has your cancer registry been in place?

◉ 1 Year (minimum) ○ <5 Years ○ > 5 Years Reference Year

Survey Information

Anticipated date of survey (Month/Year):

Indicate the day your program hold its Cancer Conference? Friday

Information Confirmation

I attest to the validity of the content of this application and confirm our center's readiness to proceed with the accreditation process. Please contact us to schedule your initial accreditation survey.

Signature of Cancer Committee Chair or other person accepting on behalf of the facility. (Electronic Signature)

Name:

Title: Date :