



(ARCH)DIOCESAN REQUEST FOR LUMEN ACCREDITATION

Welcome! To begin the process of bringing Lumen Accreditation to your diocese, please complete and submit the information found below.

Diocesan Information

Diocese Name: _____

Address: _____

City: _____ State: _____ Postal Code: _____

Bishop: _____

Catholic Schools Office? (yes/no)

Superintendent of Catholic Schools:

Name (first, last): _____

Position: _____

Email: _____

Phone: _____

Catholic Schools Office Webpage: _____

Schools Information

Number of Schools (total): _____

Elementary _____

Middle _____

Secondary _____

K-12 _____

Grades for accreditation (please circle all that apply):

K 1 2 3 4 5 6 7 8 9 10 11 12

Total enrollment (K-8): _____

Total enrollment (9-12): _____

Does your diocese include early learning programs (pre, pre-k...)? (yes/no)

If so, how many? _____

Licensed by: _____

Total enrollment: _____

Please note that we do not currently offer accreditation for early learning programs

Does your diocese have plans to add additional schools in the future? (yes/no)

If so, please explain: _____

Instructional Delivery

Please check one:

Online

In Person

Both

Demographic Information (Race)

Please reference your NCEA data form and indicate the percentage of students in the diocese who are:

American Indian/Native Alaskan: _____%

Asian: _____%

Black _____%

Native Hawaiian/Pacific Islander: _____%

Multiracial: _____%

White: _____%

Unknown: _____%

Demographic Information (Ethnicity)

Please reference your NCEA data form and indicate the percentage of students in the diocese who are:

Hispanic/Latino: _____%

Not Hispanic/Latino: _____%

Governance Information

Number of parish schools in your diocese: _____

Number of diocesan schools in your diocese: _____

Number of independent schools in your diocese: _____

Current Accreditor

Are you currently accredited under another agency? yes/no

If yes, which one? _____

Diocesan Contact for Accreditation

Primary contact

Check this box if the primary contact is the superintendent listed above

Name (first, last): Dr ▾ _____

Position: _____

Email: _____

Phone: _____

Secondary contact

Name (first, last): Dr ▾ _____

Position: _____
Email: _____
Phone: _____

Billing Contact

Name (first, last): **Dr** ▾ _____
Position: _____
Address: _____
City: _____ State: _____ Postal Code: _____
Email: _____
Phone: _____

Additional notes or comments for Lumen staff:

For Office Use Only

Date Received: _____

Date Accepted: _____