

## Maintenance by Examination Form

### Contact Information

Identification (ID) is required at exam entrance — your **first and last name** listed here must **exactly** match the **two** forms of ID required. Please see the [Certification Handbook](#) for requirements and examples of acceptable identification.

*Your contact information will be updated in your ACRP profile as entered here.*

First Name: \_\_\_\_\_ Middle (optional): \_\_\_\_\_

Last Name: \_\_\_\_\_

E-mail: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_ Postal Code: \_\_\_\_\_

### Payment

The Exam fee is listed below. Please take note of the date and your membership status when submitting payment. This form must be received by the current *Certification* Exam application due date.

2020 Dates	Member Exam Fee	Non-Member Exam Fee
<b>Early Bird</b> Fall: May 15 – Jun 30, 2020	\$300	\$350
<b>Regular Dates</b> Fall: Jun 1 – Sept 15, 2020	\$325	\$400

**I am applying for the following *Certification* exam period:**

September 2020      Form and payment accepted May 15, 2018 – September 15, 2020 (Certification expiration is date November 30, 2020)



Exam must be taken before Certification expires. I am applying for the following exam:

CCRC<sup>®</sup>

CCRA<sup>®</sup>

CPI<sup>®</sup>

Accepted forms of payment include check, credit card, or bank transfer. Contact ACRP at [office@acrpnet.org](mailto:office@acrpnet.org) for bank transfer details. *Select payment method below:*

### Credit Card

Card Type:                    MasterCard                    Visa                    American Express

Card #: \_\_\_\_\_ Exp. Date: Month: \_\_\_\_\_ Year: \_\_\_\_\_

Name as it appears on card: \_\_\_\_\_

Cardholder's Signature: \_\_\_\_\_

### Check (Check #: \_\_\_\_\_)

*Please make your check payable to **Academy of Clinical Research Professionals** and mail this form and payment via tracked courier service to:*

ACRP Certification Program  
99 Canal Center Plaza  
Suite 150  
Alexandria, VA 22314

### Agreement and Signature

By submitting this form, I am requesting to take the current exam prior to my *Certification* expiration date. I understand that I must schedule an exam appointment, pass the current exam and submit the results confirmation with an application for *Maintenance of Certification* prior to the expiration of my *Certification*.

**Certificant's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Please allow ten (10) days for email confirmation containing important Exam scheduling details.*

Fax to: +1.703.254.8102 or e-mail to: [certification@acrpnet.org](mailto:certification@acrpnet.org)