

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 <u>Certification Handbook</u> 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.

| 2017 Dates | Member Exam Fee | Non-Member Exam Fee |
|--|-----------------|---------------------|
| Early Bird Spring: Oct 19 – Dec 1, 2016 Fall: May 1 – Jun 14, 2017 | \$300 | \$350 |
| Regular Dates Spring: Dec 2, 2016 – Feb 3, 2017 Fall: Jun 15 – Aug 14, 2017 | \$325 | \$400 |

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

| March 2017 | Form and payment accepted October 17, 2016 – February 3, 2017 (Certification expiration is date May 31, 2017) |
|----------------|--|
| September 2017 | Form and payment accepted May 1, 2017 – August 14, 2017 (Certification expiration is date November 30, 2017) |



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

| CCRC® | CCRA® | | CPI® | |
|---|-------------|------|-------------------|-------|
| Accepted forms of paymen office@acrpnet.org for ba | | - | | |
| Credit Card | | | | |
| Card Type: | MasterCard | Visa | American Express | S |
| Card #: | | | Exp. Date: Month: | Year: |
| Name as it appea | rs on card: | | | |
| Cardholder's Sign | ature: | | | |

Check (Check #:_____

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

Academy of Clinical Research Professionals *Certification Program* 99 Canal Center Plaza Suite 200 Alexandria, VA 22314

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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