

Maintenance by Examination

Submit this form during the current Exam application period **and** prior to your *Certification* expiration. Please read the appropriate [Maintenance of Certification Handbook](#) to be certain you are submitting a complete application to take the exam and maintain your *Certification*.

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

March 2016 Form and payment accepted October 19 – February 1, 2016
September 2016 Form and payment accepted May 2 – August 15, 2016

Your *Certification* must expire **after** the above date marked.

I am applying for the following *Certification* exam:

CCRC®

CCRA®

CPI®

If you want to take an Exam for which you are not currently certified, you must apply using the *Certification Exam* application and meet the eligibility criteria by review. Apply at www.acrpnet.org/Certification.

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: _____ Designation(s): _____ (e.g., RN, MS, MD)

Preferred E-mail: _____ Preferred Phone Number: _____

Preferred Mailing Address (check one): Business Home

Employer: _____ Title: _____

Address Line 1: _____
(include Building,/Suite/Apt/Room number)

Address Line 2: _____ City: _____

State/Province: _____ Postal Code: _____ Country: _____

Payment

The cost to take the *Certification Exam* is \$325. Payment and this form must be received by the current *Certification Exam* application due date.

I authorize and have enclosed payment in the amount of \$325.

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

Credit Card

Fax to: +1.703.254.8101 or e-mail to: office@acrpnet.org.

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:*

Academy of Clinical Research Professionals
Certification Program
99 Canal Center Plaza
Suite 200
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. Thank you.