CERTIFICATION EXAM APPLICATION CHECKLIST

CCRA®, CCRC®, CPI®, and ACRP-CP®

ACRP

Exam Dates

September 8 – October 7, 2017

*Applications must be **received by August 14, 2017.***

Application Accepted

May 1 – June 14, 2017

Member: $435 Non-Member: $485 (Early-Bird rate)

June 15 – August 14, 2017

Member: $460 Non-Member: $600 (Regular rate)

Prepare to Apply

- ☐ Read the Certification Handbook for important application steps, eligibility requirements, exam preparation, and Certification exam information for which you are responsible for understanding.
- ☐ Self-determine your eligibility ***before*** you apply. Eligibility requirements are detailed in the Certification Handbook.
- ☐ Obtain the correct application (e.g., CRA, CRC, PI, or ACRP-CP).

Complete the Application

- ☐ Apply using your full, legal name. The first and last name must match your government issued identification. Middle names are not considered.
- ☐ When completing the "Statement of Experience" section, list all positions for which the essential duties were performed. Dates of employment must match those listed on your CV/résumé.
- ☐ Include your CV/résumé. Your CV/résumé must be signed and dated with the current date of your application submission.
- ☐ Include a job description with dates of employment for ***each position*** listed in the "Statement of Experience" section to support your eligibility.
- ☐ Include a program certificate or transcript *(for clinical research education substitution only)*.
- ☐ *PI Applicants only*—Include proof of employment documents, (i.e., IRB/IEB approval letter)
- ☐ Confirm all documentation is in English. If original documentation was translated into English, it must also be submitted in the original language, with the certified translated document.
- ☐ Complete ***all*** sections completely and accurately.
- ☐ Sign "Authorization and Agreement" *(and "Payment" if paying by credit card)* sections.

Submit the Application

- ☐ Submit the ***complete*** application *(e.g., application, supporting documentation and full payment)* together. Incomplete submissions will result in a denial of eligibility.
- ☐ Ensure your application will be ***received*** by the due date.
- ☐ Submit your application via e-mail, fax, or traceable mail *(see "Payment" section for details)*. Use one delivery method only to avoid duplicate charges.
- ☐ Receive e-mail confirming the date your payment is applied.

Submit via e-mail to certification@acrpnet.org; or fax to +1.703.254.8102, or mail.

ACADEMY OF CLINICAL RESEARCH PROFESSIONALS

The Academy of Clinical Research Professionals (The Academy) is an affiliate organization of the Association of Clinical Research Professionals.

PRINCIPAL INVESTIGATOR
Certification Exam Application

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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.

First Name*: _____ Middle Name: _____

Last Name*: _____ ☐ Female ☐ Male

Designation(s): _____ Preferred E-mail: _____
(e.g.: RN, MS, MD)

Preferred Phone Number: Mobile

Number: _____ Alternative: _____

Preferred Mailing Address: Work

Employer: _____ Title: _____

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

Address Line 2: _____

City: _____ State/Province: _____

Postal Code: _____ Country: _____

PERSONAL PROFILE

I am taking this exam for

- ☐ Initial Certification (never Certified)
- ☐ Maintenance of a current Certification
- ☐ My Certification has expired

Are you requesting an accommodation during the exam for a documented disability?

- ☐ No
- ☐ Yes (Attach physician-signed, Special Accommodation Request Form)

Please check your preference(s) so that we may better serve your needs:

- ☐ Join Online Community *(members only)*
- ☐ Publish my information in the Online Certification Registry (upon obtaining Certification)
- ☐ Do not share my mailing address with other clinical research organizations

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How did you hear about the ACRP's Certification Program?

- ☐ ACRP Publications (*Clinical Researcher, etc.*)
- ☐ Advertisement
- ☐ Chapter Event
- ☐ Colleague Referral
- ☐ Direct Mail
- ☐ E-mail
- ☐ Interest in Certification
- ☐ Internet
- ☐ Member Referral
- ☐ Supervisor Referral
- ☐ Other:

DOCTORATE LEVEL DEGREE

A Doctorate level degree (DDS, MD or equivalent degree such as DO, MBBS or MBChB, PhD, PharmD, DNP) OR a licensed Physician's Assistant or Nurse Practitioner who has served in a PI role, is required to have been completed for the CPI program.

Degree Title: _____ Completion Date: _____

☐ I have listed on the CV, the educational institution, location (city, state, country), title of degree and date awarded.

Substitution for Work Experience Requirements

Complete this section only if you hold a current ACRP Certification and are substituting it for 1,500 hours of work experience OR if you are substituting completion of a clinical research education program in lieu of 1 of the 2 required years of employment. Applicants may only choose one option below as a valid substitute. Check one box below:

☐ **Clinical Research Certifications (Option 1)**

The Academy acknowledges that there is a shared knowledge base between CCRC and CCRA certificant holders and those who seek the CPI designation. Any candidate for the CPI designation who has a current CCRC or CCRA designation will have achieved a valid substitute for 1,500 hours of the required professional experience performing the essential duties of a CPI. Please indicate which ACRP Certification you hold by checking one of the boxes below: ☐ CCRC ☐ CCRA

☐ **Clinical Research Education Programs (Option 2)**

Please see **Substitution for Work Experience Requirements** in the Certification Handbook to determine if your educational program is acceptable.

School Name: _____ Program Title: _____

City, State/Territory: _____ Country: _____

Dates Attended–From: _____ To: _____
(month / year) *(month / year)*

Number of Hours: _____

- ☐ I have included a copy of my certificate of completion or final transcript.
- ☐ I have included the program's list of topics, syllabus, or course catalogue, or my transcript showing course titles.
- ☐ I have verified that the program was offered by an **accredited institution**.

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STATEMENT OF EXPERIENCE

Proof of Employment

☐ I have included signed proof of employment documents *(i.e. 1572/PHS 398/QIU or equivalent, IRB/IEC approval letter, copy of Investigator Agreement/Protocol signature page or other regulatory authority document verifying your role as a Principal Investigator on the clinical trial being submitted)* containing my name–one each for at least two (2) of the most recent five (5) years.

Statement of Experience

List all positions for which the Essential Duties of a PI were performed. If you wish to add additional employers, please print additional copies of this page (one for each additional employer) and submit these pages with your completed application.

Employer: _____ Supervisor (Name, Title): _____

Supervisor E-mail: _____ Phone: _____

Employer City, State/ Territory: _____ Country: _____

Employment Dates–(Start): _____ (End): _____
(month / year) *(if currently employed here, use today's date)*

Essential Duties

Check each essential duty performed during the time period listed. *At least one must be selected:*

- ☐ Responsible for the safe and ethical conduct of a clinical trial;
- ☐ Evaluates the study proposal and decides on participation;
- ☐ Facilitates or verifies formal approvals according to regulatory requirements and International Conference on Harmonisation (ICH) Good Clinical Practice (GCP);
- ☐ Ensures that all site initiation activities are performed to start and conduct the study;
- ☐ Participates in the selection of trial subjects according to the recruitment strategy;
- ☐ Performs or supervises the conduct of study-related procedures and monitors the safety of the trial subjects and investigational staff;
- ☐ Collects accurate and verifiable data and other essential study documents;
- ☐ Ensures compliance with regulatory requirements and ICH GCP, the protocol and the handling of the investigational product;
- ☐ Communications with subjects, sponsor's personnel, and Institutional Review Board
- ☐ Ensures adequate close-out of the study

Note: *ACRP and the Academy reserve the right to verify the accuracy of this information. Please see the "Authorization and Agreement" section for more information.*

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EXAM AND APPLICATION COSTS

The total amount due with your application includes an Exam (refundable) and Application fee (non-refundable). Before applying, log on to **www.acrpnet.org** to verify your ACRP membership status and confirm the total amount due.

Application Fee (Non-refundable): Select Your Application Fee $ 0

View Fees

Exam Fee Select Your Exam Fee $ 0

TOTAL Payment: **$** 0

PAYMENT METHOD

Accepted forms of payment include check, credit card, or bank transfer. Select one below:

☐ **Check** (Check #: _____)

Please make your check payable to ***Academy of Clinical Research Professionals.***

Mail application, supporting documentation, and payment via tracked courier service to:

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

☐ **Credit Card**

Emailed, faxed, or online applications applications will **only** be accepted with credit card information. Fax to +1.703.254.8101 or e-mail **certification@acrpnet.org**.

Card Type: Card Type

Card #: _____ Expiration Date (MM/YYYY): ____ ____ Billing Zipcode: ____

Name as it appears on card: _____

Signature: _____

☐ **Bank Transfer**

Use the following to arrange money transfer from your bank *(USD only):*

Beneficiary Address:
Academy of Clinical Research Professionals
99 Canal Center Plaza, Suite 200
Alexandria, VA 22314

Beneficiary Bank Address:
HSBC Bank USA, NA
120 Broadway
New York, NY 10005

Beneficiary Account Number: 389063835

IBAN/ABA/Routing Number: 021001088

Swift Code:
MRMDUS33RTL

Submit via e-mail to **certification@acrpnet.org**; or fax to +1.703.254.8102, or mail.

ACADEMY OF CLINICAL RESEARCH PROFESSIONALS

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Mail the application, supporting documentation, and the receipt of bank transfer payment via tracked courier service to:

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

AUTHORIZATION AND AGREEMENT

By submitting this Certification application, I acknowledge and affirm that the information I have provided herein is true and correct to the best of my knowledge, I understand and agree that the Academy of Clinical Research Professionals (the Academy) may require documentation of any information included in my application—including my academic, continuing education, licensing, criminal, regulatory, and employment records—and may determine that I am ineligible for Certification if I fail to provide that documentation, and I authorize the Academy and the Association of Clinical Research Professionals (ACRP) to access, obtain, and review my academic, continuing education, licensing, criminal, regulatory, and employment records without limitation. I hereby authorize all institutions in possession of my academic, continuing education, licensing, criminal, regulatory, and employment records to release those records and report the contents of those records to the Academy and ACRP. This authorization shall automatically expire three years after this application is submitted, or three years after the expiration of my Academy Certification following my final Maintenance of Certification cycle, whichever is later. Further, I agree to hold harmless, waive any and all legal claims against, and indemnify the Academy, and ACRP and their employees, officers, directors, consultants, agents, volunteer members, and vendors, and the institutions releasing records or reporting their contents to the Academy or ACRP.

I hereby authorize the Academy of Clinical Research Professionals (the Academy), Association of Clinical Research Professionals (ACRP), and the agents, exam delivery providers, vendors, and consultants of the Academy and ACRP, to make any and all inquiries or investigations to verify my credentials, employment and work experience, criminal records, academic records, licenses, and professional standing, and by my signature herein I authorize the release of that confidential information to the Academy, ACRP, its agents, exam delivery providers, vendors, and consultants. I authorize the Academy and ACRP to use information from my application, demographic information, and subsequent Certification examination performance, professional development activities, and Maintenance of Certification activities for any lawful purpose, provided that my personal identification will not be made public. I have read and understand all of the information provided in the Certification Handbook.

The Academy may suspend or permanently revoke Certification in the event that I do not adhere to or am in violation of the ACRP Code of Ethics. I understand and agree that submitting false, misleading, or incomplete information may result in denial, suspension, or permanent revocation of Academy Certification, and/or civil or criminal legal action. I understand that I can be disqualified from taking or completing the examination, or from receiving examination scores, and may be reported to appropriate legal authorities, if ACRP determines through either proctor observation or statistical analysis that I was engaged in collaborative, disruptive, or other inappropriate behavior during administration of the examination. In the event of disqualification, suspension, or permanent revocation of Certification, I release ACRP and the Academy from any liability.

Applicant's Signature: _____ Date: _____