# CERTIFICATION EXAM APPLICATION CHECKLIST

## CCRA®, CCRC®, CPI®, and ACRP-CP®

**ACRP**

### Exam Dates
**February 20 – April 3, 2020**

*Applications must be **received by February 29, 2020***

### Application Accepted
**November 1, 2019 – December 31, 2019**
*Member: $435 Non-Member: $485 (Early-Bird rate)*

**January 1, 2020 –  February 29, 2020**
*Member: $460 Non-Member: $600 (Regular rate)*

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

### Complete the Application
- o Apply using your full, legal name.  The first and last name must match your government issued identification (middle names are not considered).
- o When completing the "Experience" section, list all positions for which the essential duties were performed.  Dates of employment must match those listed on your current CV/ résumé.
- o Include your CV/résumé – must be signed and dated with the current date of your application submission.
- o Include a job description with dates of employment for **each position** listed in the "Experience" section to support your eligibility.
- o Include your degree or transcript (for clinical research education substitution only).
- o *PI applicants only* – include proof of employment documents (i.e., IRB/IEB approval letter)
- o 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 translate document.
- o Complete **all** sections completely and accurately

### Submit the Application
- o Submit the **complete** application (e.g., application, supporting documentation, and full payment) together.  Incomplete submissions will result in a denial of eligibility.
- o Ensure your application will be **received** by the due date.
- o ACRP will confirm receipt of your application by email.

# ACRP CERTIFIED PROFESSIONAL
## 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:** [_____]

Number: _____    Alternative: _____

**Preferred Mailing Address:** [_____]

Employer: _____    Title: _____

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

Address Line 2: _____

City: _____    State/Province: _____

Postal Code: _____    Country: _____

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

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# ACRP CERTIFIED PROFESSIONAL
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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:

## EDUCATION

### Education and Hours of Work Experience

Indicate the applicable education and hours of experience below.

- ☐ Bachelor's degree or higher with at least 3,000 hours of work experience
- ☐ Associate's degree or RN, LPN, LVN with at least 4,500 hours of work experience
- ☐ High School diploma, Medical Assistant or Lab Technician with at least 6,000 hours of work experience

### 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 1,500 hours of work experience. 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 CCRA, CCRC and CPI certificant holders and those who seek the ACRP-CP designation. Any candidate for the ACRP-CP designation who has a current CCRA, CCRC or CPI designation will have achieved a valid substitute for 1,500 hours of the required professional experience for the ACRP-CP exam. Please indicate which ACRP Certification you hold by checking one of the boxes below  ☐ CCRA  ☐ CCRC  ☐ CPI

- ☐ **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

List all positions from which the work experience of a Clinical Research Professional was performed. If you want to list more than one position, please include additional positions on separate sheets and attach to this 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)

Average number of hours per week performing essential job duties listed below: _____ hours

### Eligibility Requirements

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

- ☐ Planning – protocol design, feasibility assessment, business operations (budgeting, contracting, billing compliance), site selection activities, regulatory document preparation, collection, and/or submission, site management activities, clinical operations role within site, academic medical centers or CROs.
- ☐ Conducting – conduct of clinical trials with participants.
- ☐ Overseeing (management, administration) – study site management (Site, CRO, Sponsor, monitoring activities (including in-house, central and remote monitoring), project management, quality control, quality assurance, data management, medical monitoring, safety monitoring (medical safety liaison, pharmacovigilance, IRB professional).

**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.*

## 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): [                    ]        $ _____

Exam Fee : [                    ]        $ _____

**TOTAL Payment:**        $ _____

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

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## 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 150A
Alexandria, VA 22314

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

Card Type: [                    ]

Card #: _____ Exp. 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<br>Certification Program<br>99 Canal Center Plaza, Suite 150A<br>Alexandria, VA 22314 |
| **Beneficiary Account Number:** | 389063835 |
| **Beneficiary Bank Address:** | HSBC Bank USA, NA<br>120 Broadway<br>New York, NY 10005 |
| **Swift Code:** | MRMDUS33RTL |
| **IBAN/ABA/Routing Number:** | 021001088 |

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# ACRP CERTIFIED PROFESSIONAL
## Certification Exam Application

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 150A
> 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: _____

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