ACRP PROJECT MANAGER
Subspecialty Exam Application

ACRP

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.

First Name*: _____ Middle Name: _____

Last Name*: _____ ☐ Female ☐ Male

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

Preferred Phone Number: Select

Number: _____ Alternative: _____

Preferred Mailing Address: Select

Employer: _____ Title: _____

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

Address Line 2: _____

City: _____ State/Province: _____

Postal Code: _____ Country: _____

PERSONAL PROFILE

I currently hold a valid ACRP Certification (please check all that apply):

- ☐ Certified Clinical Research Associate (CCRA)
- ☐ Certified Clinical Research Coordinator (CCRC)
- ☐ Certified Principal Investigator (CPI)
- ☐ ACRP Certified Professional (ACRP-CP)

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

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.

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EXAM AND APPLICATION COSTS

Before applying, log on to www.acrpnet.org to verify your ACRP membership status and confirm the total amount due.

Exam Fee Select Your Application 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 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: Select
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 99 Canal Center Plaza, Suite 150A Alexandria, VA 22314
Beneficiary Account Number:	389063835
Beneficiary Bank Address:	HSBC Bank USA, NA 120 Broadway New York, NY 10005

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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Swift Code: MRMDUS33RTL
IBAN/ABA/Routing Number: 021001088

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: _____