



## 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 [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: \_\_\_\_\_

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.

| 2020 Dates  | Member Exam Fee | Non-Member Exam Fee |
|---|-----------------|---------------------|
| <b>Early Bird</b><br>Fall: May 15 – Jun 30, 2020    | \$300           | \$350               |
| <b>Regular Dates</b><br>Fall: Jun 1 – Sept 15, 2020 | \$325           | \$400               |

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

July -15 - October 15, 2020 Form and payment accepted May 15 – September 15, 2020  
(Certification expiration is date November 30, 2020)

# ACADEMY

OF CLINICAL RESEARCH PROFESSIONALS



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

CCRC®

CCRA®

CPI®

ACRP-CP®

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

## Credit Card

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:*

ACRP Certification Program  
99 Canal Center Plaza  
Suite 150 A  
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.*

Fax to: +1.703.254.8102 or e-mail to: [certification@acrpnet.org](mailto:certification@acrpnet.org)