Application for CACRS Certification

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name________________________________MI_______Last Name___________________________

Title____

Company____

Preferred Mailing Address (Check One):

❑ Business ❑ Home

Address____Mail Stop________________Suite/Apt________________

City/ State/Province/Zip/Postal Code ____

Country____

Phone (with area/country code) ____

Email Address (required for confirmation)____

CERTIFICATION FEES ***(All fees in Canadian dollars)***

Paid by due date

Certification Application and Fee (Submitted on : / / /			
CACRS Member Pricing (CAD)		**Non-member Pricing (CAD)**	
❑ $360	Submitted on: / /	❑ $530	Submitted on: / /

METHOD OF PAYMENT

- **International Wire Transfer:** email this completed form and copy of bank wire confirmation to confirm your registration to: CACRS account (CACRS bank account should be requested by email via: certification@cacrs.com). All bank charges are the responsibility of the payer.
- **Check #**____________________
- **Credit Card** (check which card you will use) ❑ American Express ❑ MasterCard ❑ Visa

  Account #____Exp. Date____

  CVV (Card Security Code) ____

  Name as it appears on the card____________________________________Signature _____________________________________

APPLICATION CHECKLIST

Please check each box indicating your agreement that each specific task is complete <u>PRIOR</u> to submitting the application.

❑ **Applicant information:** I completed the applicant information and noted the email address to which CACRS correspondence should be sent

❑ **Payment:** I included payment information with this application

❑ **Terms and Association's Policy Agreement:** I have read and acknowledged the all terms and policy

❑ **Maintain Documentation Supporting List of Clinical Research Training Certificate, Degree and Resume/CV:** I acknowledge that should the CACRS Program Office contact me to supply proof of reported activities, I will respond within a reasonable amount of time, not to exceed 30 days.

❑ **Certification for the Program- check the relevant box:** ❑ CCRS ❑ CCRN ❑ CCRPA ❑ CCRPh ❑ OCCRS

APPLICATION AGREEMENT

The signing and submission of this application indicates you have read and understand the CACRS policies and procedures contained in the CACRS Certification Guide. Your signed application submission also signifies agreement that the information submitted in this application is complete and accurate and that you agree to comply with the terms of a CACRS certification Program Office audit. The CACRS Program Office reserves the right to audit up to 5 percent of submissions each year. You will be contacted if you are among those randomly selected and will be required to follow up with the documentation supporting your clinical research training certificate, degree and resume/CV highlighting job description.

❑ By purchasing an CACRS application or renewal, I provide consent that my profile will be stored with CACRS and shared with processors for the purpose of doing business with CACRS. I consent to receiving announcements from CACRS and that I can opt-out at any time by contacting CACRS or updating preferences.

I also hereby understand and agree to the privacy policy provided on CACRS.com

Signature____Date _____________________________________

Questions? Please contact CACRS (Canadian Association of Clinical Research Specialists) at: certification@cacrs.com