

Application for CACRS Recertification



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) _____

RECERTIFICATION FEES *(All fees in Canadian dollars)*

Paid by due date

Recertification Application and Fee (Submitted on : / /)			
CACRS Member Pricing (CAD)		Non-member Pricing (CAD)	
<input type="checkbox"/> \$350	Submitted on: / /	<input type="checkbox"/> \$480	Submitted on: / /

Paid after due date [but within one year of due date]

LATE Recertification Application and Fee (Amount due in total if application received after the due date of recertification test cycle)			
CACRS Member Pricing (CAD)		Non-member Pricing (CAD)	
<input type="checkbox"/> \$470	\$350 + \$120 late fee	<input type="checkbox"/> \$730	\$480 + \$250 late fee

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 **PRIOR** 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
- Professional Development Activities:** I obtained at least 24 credits of qualifying professional development activities within my current 2-year recertification cycle
- Completed List of Professional Development Activities:** I have completed the Professional Development Tracker on page 2, which accurately lists relevant clinical research professional activity, date, and accumulated CACRS recertification credits
- Terms and Association's Policy Agreement:** I have read and acknowledged the all terms and policy
- Maintain Documentation Supporting List of Clinical Research Professional Activities:** 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.
- Recertification for the Program- check the relevant box:** CCRS CCRN CRPA CRRPh

APPLICATION AGREEMENT

The signing and submission of this application indicates you have read and understand the CACRS policies and procedures contained in the CACRS Recertification 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 recertification 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 list of clinical research professional activities and associated credits.

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

