APCR
Academy of Physicians in Clinical Research

Membership Application

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apcrnet.org

Member Information:

Prefix: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Prof. ☐ Dr.

First Name_____ M.I.____ Last_____ Degree(s)_____

Company_____

Title_____

Mailing Address_____

Mailing Address_____

City_____ State_____ Zip Code_____ Country_____

Email Address_____

Contact Phone Number_____ Fax Number_____

Date of Birth_____ Education: Medical Degree_____ Year_____

Profession: ☐ Trainer ☐ Educator ☐ Investigator ☐ Site Manager ☐ Site Coordinator ☐ Student ☐ Statistics
☐ Quality Assurance ☐ Monitor ☐ Medical Officer ☐ Other_____

Are you interested in pursuing the Certified Principal Investigator (CPI) credential? ☐ Yes ☐ No ☐ Unsure

How did you learn about APCR?

☐ Colleague (Name:_____) ☐ Mail/Brochure/Website

☐ Convention/Meeting (Name_____) ☐ Other_____

Type of Membership:

APCR membership is limited to physicians directly or indirectly engaged in clinical research endeavors. Resident members must submit a letter from your program director or school registrar stating date of completion. Professional membership rates ($USD) are determined by your geographic location.

☐ $300 Active Member ☐ $100 APCR Resident Anticipated year of completion: _____

Payment Info::

Credit card type: ☐ AmEx ☐ Visa ☐ M/C ☐ Check#_____

Cardholder Name_____

Credit Card Number_____ CVV_____ Exp. Date_____

Cardholder Signature_____

Dues payments, contributions or gifts to APCR are not tax deductible as charitable contributions for federal income tax purposes. However, they may be deductible as ordinary and necessary business expenses. Please consult your tax advisor.