SOCRA®

SOCIETY OF CLINICAL RESEARCH ASSOCIATES

Certification Preparation and Review Course
Late Transfer Form Acknowledgement
**for requests after refund cut-off date* but before course start date*

Today's Date _____

Workshop Title/ID # _____

Workshop Date(s) _____

Please check which is applicable:

☐ I am unable to attend the above listed workshop, and request that you please mail the workshop book to me at the following address:

_____

_____

_____

☐ Please transfer my registration for the above listed workshop to the upcoming scheduled date and location I have noted below:

_____

Workshop Name/ ID # Date/Location

You may charge my credit card the $50.00 late transfer fee:

VISA ☐ M/C ☐ AMEX ☐ Expiration date _____/_____

Amount $_____ Account # _____

_____

Cardholder Name

_____

Cardholder Signature

I understand this is a one-time accommodation.

Your Signature _____

Print Name _____

530 West Butler Avenue, Suite 109 Chalfont, PA 18914 USA
Phone (800) 762 7292 or +1 215 822 8644 Fax +1 215 822 8633
E-mail SoCRAmail@aol.com www.SoCRA.org