



SOCIETY OF CLINICAL RESEARCH ASSOCIATES

Certified Clinical Research Professional - Re-Certification Application

Re-certification is required every three years and the candidate: 1) must have completed 45 hours (45 credits) of Continuing Education; one clinical credit is given for taking the re-certification quiz; **22 hours must relate to clinical research regulations, policy, operations, etc., the balance may relate to your work in research (therapy, treatment, etc.)**, and 2) must successfully complete a self-administered knowledge test that will be included with the three-year re-certification reminder package. Please complete the following information for each continuing education program to be applied to your re-certification. Please retain all original certificates of attendance and documentation for five (5) years and submit such documentation only when requested to do so for audit purposes. Please use additional copies of this form as necessary.

You will be given two opportunities to receive a passing score of 80% or greater. If you are unsuccessful after the second attempt, you will have the option to reapply to sit for the full certification examination under our current certification application/eligibility requirements.

I hereby certify that hours claimed pertain to my current competency or further enhanced my clinical research knowledge and research abilities.

Name _____ Email _____

Member ID _____ Telephone _____ Fax _____

Total Hours claimed (at least 45) _____ Signature _____

Continuing Education Credit Record (please attach additional pages as needed)					
Date	Sponsor	Program Title	Course ID #	Therapeutic Contact Hrs.	Clinical Operations/Regulatory Contact Hrs.

Please make your **check** for the (*non-refundable*) processing and record keeping fee payable to "SoCRA" (Specify \$100.00 in US Funds if your check is drawn on a non-US bank).

If you are submitting the (*non-refundable*) processing fee by **credit card**, please complete the following and mail or fax this form with your application information to SoCRA.

VISA ___ M/C ___ AMEX ___ Expiration date ___/___/___ Amount \$ 100.00

Account number _____ Credit Card Zip Code _____

Signature _____ Print Last Name _____

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