

LOGO Here

Clinical Research Nurse Certification and Recertification Application

Candidate's Name _____

Name as you would like it to appear on certificate upon earned credentials _____

Email Address _____

Telephone number _____ Cell number _____

Mailing Address _____

It is the responsibility of the individual CRN to notify the Clinical Research Nurse Certification Council (CRNCC) of change in their name and/or address. CRNCC is not responsible for notices that fail to reach the Clinical Research Nurse (CRN).

I attest to having an, unencumbered RN license Yes No

State of Licensure _____

License Number _____

My name may be published as having earned Clinical Research Nurse Certification Yes No

IACRN membership status: (choose one):

I am a current IACRN member with

I am NOT a current IACRN member

Expiration date: _____

Fee: \$495

Fee: \$345

All fees are non-refundable and non-transferable

I am submitting this certification packet for: (choose one):

Initial certification (initial, expired or otherwise non-continuing)

Recertification of existing credentials

Current Employer _____ Role _____ Title _____

Number of years as an RN _____ Number of years in clinical research _____

My signature affirms that all information submitted for the purpose of certification or recertification consideration is accurate and complete. It is my understanding that certification and recertification is based solely on the submitted materials and will be denied for any of the following reasons:

Falsification of application; Misrepresentation; Failure to meet criteria for contact hours/points per policy; Failure to provide requested information/documentation requested during audit; Failure to meet experiential requirement; Lack of current unencumbered RN license; Failure to submit appropriate fees; Failure to apply by deadline.

Electronic signature

Today's Date