



Membership Application

- Full (\$135)
 Full – 2 yr (\$243)
 Associate (\$135)
 Associate – 2 yr (\$243)
 Student (\$70)
 Developing Country Member (\$25)

Join us!

Please complete all the fields below.

Full Name _____

Credentials _____

Employer _____

Address _____

Country _____

Preferred Contact Email _____

Preferred Phone Number _____

Research Certifications _____

License State _____

Please select which of the categories below best describes your primary/current role:

- Direct Care Giver
- Study Coordinator/Project Manager
- Recruitment Specialist
- Manager/Administrator
- Educator
- Clinical Research Monitor
- Consultant
- Ethics Committee Administrator/Staff
- Advanced Practice Nurse
- Other, please describe: _____

Specialty Area (select all that apply):

- Allergy and Clinical Immunology
- Anesthesiology
- Cardiology
- Critical Care
- Dental
- Dermatology
- Emergency Medicine
- Endocrinology
- Family Health
- Gastroenterology
- Gerontology
- Gynecology and Obstetrics
- Hematology
- Home Health
- Hospice/Palliative Care
- Infectious Diseases
- Internal Medicine
- Nephrology
- Neurology and Neurosurgery
- Nutrition Support
- Oncology
- Ophthalmology (Eyes)
- Orthopedics
- Otolaryngology
- Pediatrics
- Physical Medicine/Rehabilitation
- Psychiatry/Behavioral Sciences
- Pulmonary
- Radiology
- Rheumatology
- Surgery-General
- Vascular Medicine, Surgery, & Endovascular Therapy
- Not Applicable/Other: _____

Practice Setting:

- Community Practice/Private Practice
- Hospital Outpatient/Clinic
- Hospital Inpatient
- Industry (drug, biologic, device)
- Contract Research Organization (CRO)
- Site Management Organization (SMO)
- IRB
- Dedicated Research Unit/Center
- Academia (College/University Faculty)
- Health Plans
- FDA/OHRP
- Self-employed
- Retired
- Not currently employed
- Other, please specify: _____

Please return this form with payment to IACRN Headquarters

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Forest Hill, MD 21050

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www.iacrn.org