

# Membership Application Form

**PLEASE COMPLETE IN BLOCK CAPITALS** and return to The Institute of Clinical Research, Cedar Court, Grove Park, White Waltham, Berkshire, SL6 3LW, U.K  
 Fax: +44 (0) 1628 501709 Phone: +44 (0) 1628 501700  
 Email: Office@icr-global.org



Section 1 - Personal Details	
Title (Dr/Mr/Mrs/Miss/Ms) _____ Initials _____ First Name(s) _____ Last Name _____ Date of Birth (dd/mm/yy) _____ Sex: Male <input type="checkbox"/> Female <input type="checkbox"/> Years in Clinical Research _____ Have you previously been a member of the ICR? No <input type="checkbox"/> Yes <input type="checkbox"/> (Mem. no: _____) Your home address: _____ _____ _____ Your full company name: _____ Work address: _____ _____ Direct Tel: _____ Mobile: _____ E-mail: _____	Preferred correspondence: Home <input type="checkbox"/> Work <input type="checkbox"/> <b>Qualifications</b> (Please tick as many as relevant) <input type="checkbox"/> Q01- Level 3 (A Level, HND, NVQ3, etc.) <input type="checkbox"/> Q02- ICR: Cert. Prof. Dev. <input type="checkbox"/> Q03- ICR: PgCert. Clin. Res <input type="checkbox"/> Q04- ICR: PgCert. Clin. Trial. Admin. <input type="checkbox"/> Q05- ICR: PgDip. Clin. Res. <input type="checkbox"/> Q06- ICR: MSc. Clin. Res. <input type="checkbox"/> Q07- Bachelor's Degree in science subject <input type="checkbox"/> Q08- Bachelor's Degree in non-science subject <input type="checkbox"/> Q09- Master's Degree (e.g. MSc, MMedSci, etc.) <input type="checkbox"/> Q10- PhD or equiv. (DPhil, DPharm, DMed) <input type="checkbox"/> Q11- Nursing qualification <input type="checkbox"/> Q12- Other _____ <input type="checkbox"/> Q13- ICR: Membership Exam- Part 1 <input type="checkbox"/> Q14- ICR Membership Exam- Part 2 <input type="checkbox"/> Q15- ICR: Global GCP Certification Exam
Section 2 - Affiliation	Section 3 - Class of Membership
Please tick only one option. <input type="checkbox"/> AF01 – Pharma company <input type="checkbox"/> AF02- CRO <input type="checkbox"/> AF03- SMO <input type="checkbox"/> AF04- Biotech company <input type="checkbox"/> AF05- Ethics Committee <input type="checkbox"/> AF06- Medical device company <input type="checkbox"/> AF07- Service company (e.g. printer, laboratory, trial supplies, etc) <input type="checkbox"/> AF08- Freelance <input type="checkbox"/> AF09- Academic Institution/ Health Service <input type="checkbox"/> AF10- Student <input type="checkbox"/> AF11- Retired	Please select the appropriate subscription rate (Please tick the discounted rate if you are employed by an academic institution, a national health service or are a student). Please refer to the Membership Guidance Notes.*Additional evidence may be requested  Affiliate <input type="checkbox"/> £60 <input type="checkbox"/> Discounted £45* Registered <input type="checkbox"/> £88 <input type="checkbox"/> Discounted £66* Professional <input type="checkbox"/> £116 <input type="checkbox"/> Discounted £87* Fellow <input type="checkbox"/> £144 <input type="checkbox"/> Discounted £108*
Section 4 - Data Protection Act 1998	Section 5 - Where did you hear about ICR?
<input type="checkbox"/> Please tick to indicate you have read and understood the following statement: I understand that by signing this application form my personal details will be used for updating and managing my membership record, defining areas of special interest to me, delivering products and services and advising me of other products and services appropriate to my declared interests. The ICR will not sell members details to a third party.	<input type="checkbox"/> From an ICR member of staff or representative <input type="checkbox"/> From a current member or colleague <input type="checkbox"/> On the Internet <input type="checkbox"/> Via a training course or ICR event <input type="checkbox"/> Other _____
Section 6 – Payment Methods	
<b>IMPORTANT: please consider paying by credit/debit card as these are the most cost effective ways for the Institute to process your payment.</b> <input type="checkbox"/> Debit Card <input type="checkbox"/> Credit Card (Please note payments are subject to a 3% charge) <input type="checkbox"/> American Express (Please note payments are subject to an administration charge) <input type="checkbox"/> EC I authorise The ICR to debit my account with £ _____ Card No: _____ _____ Expiry date: ____/____	<input type="checkbox"/> BACS: Contact The Institute of Clinical Research for bank details- <a href="mailto:membership@icr-global.org">membership@icr-global.org</a> OR <a href="mailto:accounts@icr-global.org">accounts@icr-global.org</a> – and quote your membership number as a payment reference. <input type="checkbox"/> Cheque: I enclose a cheque for £ _____ made payable to The Institute of Clinical Research <input type="checkbox"/> Invoice: I request that an invoice for the amount of £ _____ to be sent to my company (details provided). NB: Invoices cannot be raised if purchase order number/reference not provided. Purchase Order No: _____
Section 8 - Declaration	
By signing this application for membership of The Institute of Clinical Research I undertake to pay £1 to the Institute's assets if it should be wound up whilst I am a member or within one year after I cease to be a member, for payment of the company's debts and liabilities and of the costs, charges and expenses of winding up and will abide by ICR's Professional Code of Conduct. I also confirm my commitment to CPD and will provide evidence of achieving 60 points per annum on request if accepted as a Professional member or Fellow. All of the above details are true and correct. Signed: _____ Date: _____	

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