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

The Institute of Clinical Research

Section 1 - Personal Details

Title (Dr/Mx/Mr/Mrs/Miss/Ms/) _____
Initials_____
First Name(s)_____
Last Name_____
Date of Birth (dd/mm/yy)_____
Gender: Male ☐ Female ☐ Unspecified ☐
Years in Clinical Research _____
Have you previously been a member of the ICR?
No ☐ Yes ☐ (Mem. no:_____)
Your home address:_____
_____
_____
Your full company name:_____
Work address:_____
_____
_____

Direct Tel:_____
Mobile:_____
E-mail:_____
Preferred correspondence: Home ☐ Work ☐

Qualifications *(Please tick as many as relevant)*
☐ Q01- Level 3 (A Level, HND, NVQ, etc.)
☐ Q02- Bachelor's Degree in science subject
☐ Q03- Bachelor's Degree in non-science subject
☐ Q04- Master's Degree (e.g. MSc, MMedSci, etc.)
☐ Q05- PhD or equiv. (DPhil, DPharm, DMed)
☐ Q06- Nursing qualification
☐ Q07- ICR: Certificate Exam
☐ Q08- ICR: Diploma Exam
☐ Q09- Other: _____
_____

Section 2 - Affiliation

Please tick only one option.
☐ AF01 – Pharma company
☐ AF02- CRO
☐ AF03- SMO
☐ AF04- Biotech company
☐ AF05- Ethics Committee
☐ AF06- Medical device company
☐ AF07- Service company (e.g. printer, laboratory, trial supplies, etc)
☐ AF08- Freelance
☐ AF09- Academic Institution/ Health Service
☐ AF10- Student
☐ AF11- Retired

Section 3 - Class of Membership

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	☐ £60	☐ Discounted £45*
Registered	☐ £88	☐ Discounted £66*
Professional	☐ £116	☐ Discounted £87*

Section 4 - Data Protection Act 1998

☐ 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.

Section 5 - Where did you hear about ICR?

☐ From an ICR member of staff or representative
☐ From a current member or colleague
☐ Via the Internet
☐ Via Social Media
☐ Via a training course or ICR event
☐ Other_____

Section 6 – Payment Methods

IMPORTANT: please consider paying by credit/debit card as these are the most cost effective ways for the Institute to process your payment.
☐ Debit Card
☐ Credit Card
☐ American Express *(Please note payments are subject to an administration charge)*
☐ EC
I authorise The ICR to debit my account with £_____
Card No:
☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐
Expiry date: ☐☐ / ☐☐

☐ BACS: Contact The Institute of Clinical Research for bank details- office@icr-global.org – and quote your membership number as a payment reference.

☐ Cheque: I enclose a cheque for £_____ made payable to The Institute of Clinical Research

☐ Invoice: Please complete form on reverse of page.

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: _____

ONLY COMPLETE IF PAYMENT IS BY INVOICE

Accounts Payable Contact Details

Invoice: I request an invoice for the amount above to be sent to my company, details provided below. ***(NB: Invoices cannot be raised if purchase order number/reference not quoted).***

Company Name: _____

Accounts
Invoice address: _____

_____

_____

Accounts Contact Name: _____

Accounts Contact Number: _____

Accounts Contact E-Mail: _____

Purchase Order Number:

Signed _____ **Date:** _____