Rev. 6 SEPT 2018

Consortium of Academic Programs in Clinical Research

CoAPCR Membership Application
Institutional Member

Program and Institution

Institution name: _____

Program name: _____ College/Department: _____

Program website: _____

Contact

Program director/ coordinator name: _____ Phone: _____ Email: _____

Other contact name (optional): _____ Phone: _____ Email: _____

Other contact name (optional): _____ Phone: _____ Email: _____

Address line 1: _____

Address line 2: _____

City: _____ State: _____ Zip: _____

Program Information

	Credit hours required	Practicum required (yes/no)	Online (yes/no)
Degree programs offered:			
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
Certificate programs offered:			
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

Program accreditation (yes/no): _____ If yes, specify type of accreditation: _____

CTSA institution (yes/no): _____ Advisory board (yes/no): _____

Please provide any additional information: _____

_____

_____

Your **Institutional Mmembership fee of $250** may be paid by check (payable to **CoAPCR**) or by credit card via PayPal on our website: http://www.coapcr.org/membership/membership-application/.

Please mail your completed application and membership fee to:

Marjorie Neidecker, PhD, RN
The Ohio State University 7623
Kestrel Way W Dublin, OH
432017
614-302-3904
neidecker.1@osu.edu