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Consortium of Academic Programs in Clinical Research

CoAPCR Membership Application
Sustaining (Individual or Organization) Member

Contact

Individual's Name: ________________________________ Phone: ______________ Email: ___________________________

Other contact name (optional): ________________________________ Phone: _____________ Email: ___________________________

Other contact name (optional): ________________________________ Phone: _____________ Email: ___________________________

Company/Institution:_______________________________ Phone:______________ Email:____________________________

Address line 1: ____

Address line 2: ____

City: ____ State: _______________ Zip: _____________________________

Website URL:____

Role in Clinical Research Professionals' Education/Training:____

Your **Sustaining Membership fee of $100** 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:

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