



CLINICAL RESEARCH BOARD

Application form for Membership Certification

For office use only:

Membership No.....

Date of approval.....

Signature of approving authority

Affix your
passport size
photograph here

Guidelines for filling membership form

1. All entries to be made in block letters
2. Do not leave any column blank
3. Please send demand draft/cheques in favour of "Clinical Research Board" payable at New Delhi.
4. For queries regarding membership of CRB please contact certification@clinicalresearchboard.org

Name:

Gender Date of Birth.....Nationality.....

Qualifications.....

Registration details: Reg. No & YearRegistration authority.....

Primary Responsibility (mark as applicable) Research Teaching Administration Patient Care Other

Affiliation (mark as applicable) Hospital Private Practice CRO Government Industry University Other

Duration of Experience in clinical research.....

Specific research interests or activity

Current organization.....Current designation.....

Official Address.....

Contact No. Land line.....Mobile.....Fax.....

E-mailPreferred mail.....

(Pl attach zerox/scan copies of certificates/testimonials/credentials along with application form)

Permanent address (along with telephone no.).....

Current contact address for communication with CRB

(in case of change in contact address please notify CRB through mail to keep your contact details updated)

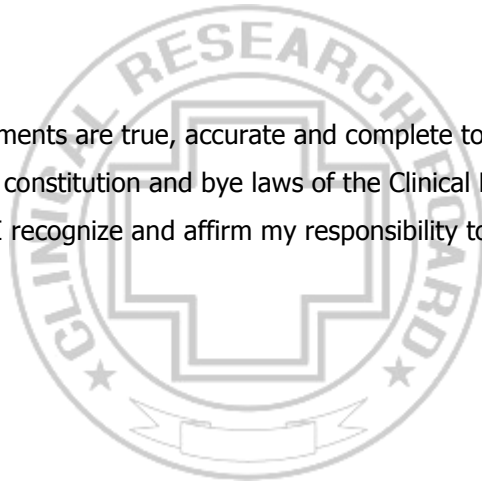
Details of Payment:

Method of payment: Bank draft/Cheque/Online

Bank draft/Cheque No/Transaction ID..... Date of Payment.....

Declaration

- I affirm that all my statements are true, accurate and complete to the best of my knowledge.
- I have gone through the constitution and bye laws of the Clinical Research Board and will abide by the same.
- As a clinical researcher, I recognize and affirm my responsibility to abide by the basic ethical principles inherent in clinical research



Signature of Applicant
Date

Clinical Research Board

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