AMERICAN CHIROPRACTIC REHABILITATION BOARD®
RECERTIFICATION RENEWAL FORM

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE #: _____ FAX #: _____

E-MAIL (**required**): _____

Please check one of the following:

____ Yes, I will recertify for this year. I understand that I will need to complete the recertification questions with a score of at least 75% by the deadline of December 31, 2011. Once completed, a registry certificate will be issued and my name will be listed in the online active registry.

____ No, I will not recertify at this time. I understand that additional fees will apply to recertify in the future.

ANNUAL RECERTIFICATION FEES: **$135.00 – due October 1, 2011**

Please check one of the following:

____ Enclosed is a check or money order in the amount of $135.00 (payable to ACRB)

____ Bill my credit card in the amount of $135.00 (Visa or MC only)

Credit card # _____ Exp Date_____

Signature _____

Please check if you would like to receive continuing education credits:
(Confirm that your state allows online credits at www.chirocredit.com)

____ Yes, I would like to obtain 4 hours of CEU's for completing the recertification process.

DC License #: _____

I certify, by my signature, that all of the information on this form is true and correct. I give permission to the ACRB® to publish my name in the online active registry.

Signature: _____ **Date:** _____

Mail form & fees to:
American Chiropractic Rehabilitation Board
335 North 120th Avenue
Holland, MI 49424

or fax to (credit card payment only):
(616) 392-9030

or e-mail to (credit card payment only):
acrbholland@yahoo.com