

**AMERICAN CHIROPRACTIC REHABILITATION BOARD**  
**MODULE THREE EXAM APPLICATION**

TESTING DATE/SITE: \_\_\_\_\_

TESTING FEE: \$300.00 (non-refundable) – payable by check or credit card (Visa or MC)

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

COUNTRY: \_\_\_\_\_

FACILITY NAME: \_\_\_\_\_

OFFICE PHONE: \_\_\_\_\_ OFFICE FAX: \_\_\_\_\_

E-MAIL: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SSN: \_\_\_\_\_

CHIROPRACTIC COLLEGE: \_\_\_\_\_

YEAR OF GRADUATION: \_\_\_\_\_

OTHER EDUCATION AND DEGREES (include CV if more spaced required):

PROFESSIONAL MEMBERSHIPS & CERTIFICATIONS (include CV if more space required):

INSTITUTION VERIFICATION OF COMPLETION OF 100 HOURS (or transcript):

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Official Title/Date

I hereby apply to sit for the examination. I certify I have completed the required 100 hours of coursework. I also give my permission to have my name published on the ACRB/ACCRS registry as a certified rehabilitation doctor.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

When this application is accepted, you will receive confirmation for the above testing date.

**Mail this application, along with the testing fee and required documentation, to:**

American Chiropractic Rehabilitation Board  
Thomas Fowler, D.C., D.A.C.R.B. – Testing Chairman  
335 North 120<sup>th</sup> Avenue  
Holland, MI 49424

Phone: (877) 366-2272

Fax: (616) 392-9030

E-mail: acrbholland@yahoo.com

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Signature: \_\_\_\_\_

**Disclaimer:** The ACRB/ACCRS does not recognize, endorse, or authorize any review courses in any way or manner for any of our examinations, either written or oral.