

# ORAL PRACTICAL EXAM APPLICATION

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

TESTING FEE: \$425.00 (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):

## APPLICATION REQUIREMENTS:

- Successful completion of modules 1, 2, and 3 ACRB written examinations
- Photocopy of Chiropractic College Diploma
- Photocopy of State or Province License

I hereby apply to sit for the examination. I certify I have completed the required 300 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: [acrboholland@yahoo.com](mailto:acrboholland@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.