MODULE TWO EXAM APPLICATION

TESTING DATE/SITE: ______________________________

TESTING FEE: $375.00 (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):

____

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 120th 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.