MODULE THREE 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.