

**AMERICAN CHIROPRACTIC REHABILITATION BOARD®**  
**RECERTIFICATION RENEWAL FORM**

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

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

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

PHONE #: \_\_\_\_\_

FAX #: \_\_\_\_\_

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

**(\*\*\*REQUIRED\*\*\*)**

**ANNUAL RECERTIFICATION FEES:      \$135.00 – due October 1, 2010**  
**(check or money order only; payable to ACRB)**

**Please check one of the following:**

\_\_\_\_\_ Yes, I will be recertifying this year. Enclosed is payment for \$135.00. I understand that I will be given a password, via e-mail, that will allow access to articles and questions on the ACRB website. The questions will need to be completed by the deadline (December 31, 2010) and I must score at least 75%. Once this process is completed, I understand that I will receive a registry certificate stating that I have recertified for this year.

\_\_\_\_\_ No, I will not be recertifying at this time. I understand that additional fees will apply to recertify in the future.

**Please check if you would like to receive continuing education credits.** Confirm that your state allows online credits at [www.chirocredit.com](http://www.chirocredit.com). Your DC license # is needed to process the credits.

\_\_\_\_\_ Yes, I would like to obtain 4 hours of continuing education credits for completion of the questions.

**DC License #:** \_\_\_\_\_

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

**Please mail form and fees to:**

American Chiropractic Rehabilitation Board  
335 North 120<sup>th</sup> Avenue  
Holland, MI 49424