

**AMERICAN CHIROPRACTIC REHABILITATION BOARD®
ORAL/PRACTICAL DIPLOMATE EXAMINATION APPLICATION**

GENERAL INFORMATION

Name _____

Address _____

City/State/Zip _____

Phone # _____

Fax# _____

E-mail _____

Date of birth _____ SSN _____

EDUCATION

Please list institution and degree received

Undergraduate _____

Graduate _____

Post-graduate _____

LICENSURE

Please list the states/provinces in which you are licensed to practice chiropractic

ACRB® Oral/Practical Diplomate Examination Application (continued)

REGISTRATION FEES - \$750.00 (non-refundable)

All fees are payable by credit card (**Visa/MC**) or **check/money order**

Please check one of the following:

_____ **Enclosed is a check or money order in the amount of \$750.00 for the oral/practical diplomate examination (payable to ACRB).** If I choose to cancel the examination, all fees are non-refundable.

_____ **Please bill my credit card in the amount of \$750.00 for the oral/practical diplomate examination.** If I choose to cancel the examination, all fees are non-refundable.

Credit card # _____

Expiration date _____

Signature _____

I hereby apply for the oral/practical diplomate examination. By my signature, I certify that all of the above information is accurate to the best of my knowledge.

Signature _____ Date _____

Once this application is received and processed, you will be sent a confirmation letter with the examination date, time and location. The letter will also explain the testing process, what you need to bring and the dress attire.

Please mail the form and fees to:

American Chiropractic Rehabilitation Board
Attn: Oral/Practical Examination
335 North 120th Avenue
Holland, MI 49424

Or fax to:

(616) 392-9030

Please direct any questions regarding the application to:

(877) 366-2272 or acrbholland@yahoo.com

