AMERICAN CHIROPRACTIC REHABILITATION BOARD®
ORAL/PRACTICAL DIPLOMATE EXAMINATION
RETEST 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

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<u>ACRB® Oral/Practical Diplomate Examination Application (continued)</u>

Please indicate which portion of the oral exam needs to be retaken:

_________ Comprehension

_________ Skills

REGISTRATION FEES

$425.00 – if both sections need to be retaken

$300.00 – if only one section needs to be retaken

All fees are payable by credit card (**Visa/MC**) or **check/money order** (payable to ACRB) and are non-refundable.

Please check one of the following:

_________ **Enclosed is a check or money order in the amount of $425.00 for both sections of the examination.** If I choose to cancel the examination, all fees are non-refundable.

_________ **Enclosed is a check or money order in the amount of $300.00 for one section of the examination.** If I choose to cancel the examination, all fees are non-refundable.

_________ **Please bill my credit card in the amount of $425.00 for both sections of the examination.** If I choose to cancel the examination, all fees are non-refundable.

_________ **Please bill my credit card in the amount of $300.00 for one section of the examination.** If I choose to cancel the examination, all fees are non-refundable.

Credit card # ____

Expiration date ____

Signature ____

ACRB® Oral/Practical Diplomate Examination Application (continued)

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