

Name: \_\_\_\_\_  
Office address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_  
Zip: \_\_\_\_\_

Facility Name: \_\_\_\_\_  
Phone Numbers: Office: \_\_\_\_\_  
Fax: \_\_\_\_\_  
Mobile: \_\_\_\_\_

E-mail (\*REQUIRED\*): \_\_\_\_\_

Levels of Certification (please check all that have been successfully completed):

Level 1 \_\_\_\_\_

Level 2 \_\_\_\_\_

Level 3 \_\_\_\_\_

Oral practical exam (passed, but paper not accepted as of yet) \_\_\_\_\_  
Diplomate \_\_\_\_\_

Annual recertification fees per year: \$135.00 (check/money order only, payable to ACRB)

Please check one of the following:

\_\_\_\_\_ Yes, I will be recertifying for this year. Enclosed is payment for the recertification fees in the amount of \$135.00. I understand that I will be given, once payment is received, a password via e-mail that will allow access to articles and questions on the ACRB website. The questions will need to be completed and I must score at least 75%. Once this is completed, I understand that I will receive notification stating that I am recertified for this year.

\_\_\_\_\_ Yes, I would like to obtain continuing education credits for completing the questions, if my state/province allows. Your DC license number is needed to complete these credits.

License #: \_\_\_\_\_

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

I certify, by my signature, that all of the information on this form is true and correct. I also give permission to have my name published on the ACRB registry as a certified rehabilitation doctor.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_