

CREDENTIALING EXAM Registration Form

For Office Use Only

Course #: _____ Amt. Paid: _____

Student #: _____ Confirm#: _____

Date Paid: _____ Ck#: _____

Submit this original application notarized along with your full payment, a copy of your professional state license and photo. (Spots cannot be held.)

Exam Date _____ Exam City _____

Mr. Dr.
Name Ms. _____

Home Address _____

City _____ State _____ ZIP _____

Phone (Home) _____ Cell # _____

EMAIL Address _____

Company Name _____ Company Website _____

Company Address _____

City _____ State _____ ZIP _____

Phone (Work) _____ Fax # _____

Profession: PT DC MD Other _____ #Years in clinical practice: _____

Professional Licensure #: _____ State Issued: _____ Expiration Date: _____

Exam Fee: \$500.00 Retake Fees: Whole Exam \$250.00 Written Only \$200.00 Performance Only \$50.00

Check payable to: The McKenzie Institute

Visa Mastercard Discover *(Please check one) Personal Card - or - Company Card

*IF C/C BILLING ADDRESS DIFFERENT THAN HOME OR WORK ABOVE, PLEASE PROVIDE HERE: _____

Cardholder Name: _____

Card #: _____ Exp. Date: _____

Signature of Cardholder: _____

**AFFIX
PHOTO
IN THIS BOX**

I, the undersigned, certify that the information on this form is correct and that the attached photo is mine. I acknowledge that I have reviewed and accept the regulations of the credentialing process stated in the Credentialing Examination Booklet.

Applicant Signature: _____

Date: _____

NOTARY STATEMENT

State of: _____ County of: _____

On this _____ day of _____

to be known to be the identical person named above and who executed the same as a voluntary act and deed.

Signed (Notary Public): _____

Printed (Notary Public): _____

My commission expires: _____

NOTARY
AFFIX
SEAL HERE

Return this form by MAIL ONLY to: The McKenzie Institute USA
432 N Franklin St, Ste 40 • Syracuse NY 13204-1491