CREDENTIALING EXAM
Registration Form

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

Exam Date ______________________ **Exam City** ______________________

Name Mr. ❑ Dr. ❑ Ms. ❑ ______________________

Home Address ______________________

City ______________________ State __________ ZIP __________

Phone (Cell) ______________________

EMAIL Address ______________________

Company Name ______________________ Company Website ______________________

Company Address ______________________

City ______________________ State __________ ZIP __________

Phone (Work) ______________________ Fax # ______________________

Profession: ❑ PT ❑ DC ❑ MD ❑ Other ______________________

Professional Licensure #: ______________ **State Issued:** ______________ **Expiration Date:** ______________

Payment Info *(please provide all information; missing or incorrect info may result in a delay in processing)*

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

❑ **VISA**
❑ **MasterCard**
❑ **Discover**

❑ **Personal card**
❑ **Company card**

❑ **Check payable to:** The McKenzie Institute

Cardholder Name: ______________________

Card #: ______________________ **Exp. Date:** ______________

Billing address: ______________________

City, ST, Zip ______________________

Signature: ______________________

I acknowledge that I have reviewed and accept the regulations of the credentialing process stated in the "Information for the Candidate" Booklet.

Applicant Signature: ______________________

Date: ______________________

Mail or Fax the form to:
The McKenzie Institute USA
432 N Franklin St, Ste 40 • Syracuse NY 13204-1559
800-635-8380 / Fax: 315-471-7636

For Office Use Only

Course #: ______________ Amt. Paid: ______________

Student #: ______________ Confirm#: ______________

Date Paid: ______________ Ck# : ______________

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