



THE MCKENZIE
INSTITUTE® USA

CREDENTIALING EXAM Registration Form

**PLEASE PRINT CLEARLY, MISSING, OR INCORRECT INFO MAY RESULT
IN A DELAY IN PROCESSING**

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

Exam Date _____ Exam City _____

Mr. Dr.
Name 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:

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

VISA
 MasterCard Personal card Check payable to: The McKenzie Institute
 Discover Company card
 Amex

Cardholder Name: _____
Card #: _____ Exp. Date: _____ CCV#: _____
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: _____

E-MAIL, FAX OR MAIL THIS FORM TO:
wendy@mckenzieinstituteusa.org
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# : _____