

CREDENTIALING EXAM

Registration Form

For Office Use Only

Course #: _____ Amt. Paid: _____

Student #: _____ Confirm#: _____

Date Paid: _____ Ck#: _____

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

Exam Date _____ Exam City _____

Mr. ☐ Dr. ☐

Name Ms. ☐ _____

Home Address _____

City _____ Prov _____ Postal Code _____

Phone (Home) _____ Cell # _____

EMAIL Address _____

Company Name _____ Company Website _____

Company Address _____

City _____ Prov _____ Postal Code _____

Phone (Work) _____ Fax # _____

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

Professional Licence #: _____ Province 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

☐ Cheque payable to: The Robin McKenzie Institute Canada

Cardholder Name: _____

Card #: _____ Exp. Date: _____

Billing address: _____

City, Prov, Postal Code _____

Signature: _____

**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: _____



Return this form by MAIL ONLY to:
The Robin McKenzie Institute Canada
72 Pinehurst Drive, Dorchester, ON, N0L 1G2
Fax: 519-268-8151

If faxing, please email your photograph to mckenziecanada@bellnet.ca