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 $75.00**

❑ **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: _____

McKenzie INSTITUTE® CANADA

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