REQUEST for
PRIVATE-PRACTICE / CLINICAL SUPERVISOR (PCS) EXAMINATION

TESTING AGENCY: Breining Institute

SECTION 1. Please type or print all of your information clearly. **MUST INCLUDE A RECENT PHOTOGRAPH OF CANDIDATE.**

Social Security Number (last 4 numbers only) | Date of Birth (Month-Day-Year) | Male | Female

First Name

Middle Name

Last Name

Address (Number, Street, Apartment or Suite Number)

City

State | USA Zip Code

Primary Telephone Number (including Area Code) | Secondary Telephone Number (including Area Code)

E-mail Address

SECTION 2. Credit Card Payment Information (if paying by credit card): Circle type of card: **VISA** or **MasterCard**

Credit Card Number | Expiration Date

Full Name on Credit Card

Breining Institute is authorized to charge the following, not to exceed $150.00, to this card. Total authorized: $ ___ .00

Identify how much you would like charged to your credit card.

Authorized Credit Card Signature | Date

SECTION 3. FEES

- ❑ **Examination Fee.** Includes the examination, only. Nonrefundable. $150.00
- ❑ **Retake Examination Fee.** Includes the examination, only. Nonrefundable. ..... $ 75.00

SECTION 4. WHICH CERTIFICATION OR LICENSE ARE YOU TESTING FOR?

Certification or License Title (please print the full title)

Name of Certification or Licensing Agency (please print the full name)

SECTION 5. DIRECTIONS FOR SUBMITTING EXAM REQUEST

Please return this form and payment by fax, e-mail or postal mail, to:
Breining Institute • 8894 Greenback Lane • Orangevale, California 95662-4019 • Fax 916-987-8823 • E-mail: College@Breining.edu

Questions? Please call Breining Institute at 916-987-2007