

**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.**

[Grid for Social Security Number (last 4 numbers only)]	[Grid for Date of Birth (Month-Day-Year)]	[Grid for Male]	[Grid for Female]
Social Security Number (last 4 numbers only)	Date of Birth (Month-Day-Year)	Male	Female

[Grid for First Name]

First Name

[Grid for Middle Name]

Middle Name

[Grid for Last Name]

Last Name

[Grid for Address (Number, Street, Apartment or Suite Number)]

Address (Number, Street, Apartment or Suite Number)

[Grid for City]

City

[Grid for State]	[Grid for USA Zip Code]	[Grid for USA Zip Code]
State	USA Zip Code	

[Grid for Primary Telephone Number (including Area Code)]	[Grid for Secondary Telephone Number (including Area Code)]
Primary Telephone Number (including Area Code)	Secondary Telephone Number (including Area Code)

[Grid for E-mail Address]

E-mail Address

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

[Grid for Credit Card Number]	[Grid for Expiration Date]
Credit Card Number	Expiration Date

[Grid for Full Name on Credit Card]

Full Name on Credit Card

**Breining Institute is authorized to charge the following, not to exceed \$150.00, to this card. Total authorized: \$ [Grid] .00**

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

[Line for Authorized Credit Card Signature]	[Line for Date]
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?**

[Line for Certification or License Title (please print the full title)]

Certification or License Title (please print the full title)

[Line for Name of Certification or Licensing Agency (please print the full name)]

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