

**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.**

<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>
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****

<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>
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Credit Card Number

Expiration Date

Full Name on Credit Card

**Breining Institute is authorized to charge the following, not to exceed \$175.00, to this card. Total authorized: \$  .00**

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

Authorized Credit Card Signature

Date

**SECTION 3. EXAMINATION FEE**

**Examination Fee.** Includes the examination, only. Nonrefundable. .... \$175.00

Exam must be scheduled and taken within three months of submitting this exam request. If the candidate does not show up for the scheduled exam time without advanced rescheduling of the exam, the exam fee will not be refunded.

**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