COUNCIL FOR HOMEOPATHIC CERTIFICATION

TOGETHER WE'RE DEFINING THE PROFESSION

Exam Retake Application

Application Date_____

First Name: _____ Last Name: _____

Other Credentials: _____ License Information (state, #, etc.): _____

Name of Clinic/Office (if any): _____

Street Address: _____

City: _____ State/Province: ____ Zip/Postal Code: _____

Work Phone: _____ Home Phone: _____ FAX: _____

Email address: _____

I hereby request to take the following on (DATE): _____

- ☐ Theory and Philosophy
- ☐ Materia Medica
- ☐ Repertory
- ☐ Human Health Sciences
- ☐ Case Analysis Exam

Signature of Applicant: _____

Please remember to include the appropriate fees and the Proctor Agreement form with this application.