American Reflexology Certification Board

2586 Knightsbridge Rd. SE
Grand Rapids, MI 49546

p: 303.933.6921
f: 303.904.0460

info@arcb.net
www.arcb.net

Authorization to Release Education Records

The applicant for ARCB Examination is to complete this page and send it, *together with the appropriate Hand or Foot Reflexology School Verification Form from the following pages*, to your reflexology school or instructor for release of your educational records. Your school or instructor should return the completed Verification Form directly to the ARCB office.

DO NOT RETURN THIS DOCUMENT TO THE ARCB OFFICE WITH YOUR APPLICATION.

To:

School/ Instructor Name: _____

Address: _____

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

From:

Your Name: _____

Address: _____

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

I am a former student and I am applying to test with the American Reflexology Certification Board (ARCB). I authorize and request that you complete and send the enclosed School Verification Form to the ARCB:

By mail: ARCB
2586 Knightsbridge Rd. SE
Grand Rapids, MI 49546

By e-mail: Scan and email to info@arcb.net

By fax: (303) 904-0460

Thank you for your immediate attention to this matter.

Student's signature: _____ **Date:** _____

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SCHOOL VERIFICATION FORM

Foot Reflexology Education

School Director/Instructor:

As a part of the application process to take the ARCB national certification examination, the student that has provided you this form is required to have you verify his / her **foot** reflexology education below and return the form directly to ARCB.

School and Student Information:

Name of School or Program: _____

If your program keeps actual transcript records, please enclose a copy with this form.

Student's name _____

Month/Year Study began: _____ Month/Year Study completed: _____

Verification of Instructional Hours:

I / We verify that the student named above has completed the following hours of instruction:

Total Hours: _____

- Total number of **in-classroom** instructional hours: _____
- Total number of **practical (hands on) in-classroom** hours: _____
- Total number of **independent study** (not homework) hours: _____
- Total number of **practical** hours outside of class: _____

Program completed? ☐Yes ☐No

Certification granted? ☐Yes ☐No Date of certification: _____

Name of Reflexology Instructor: _____

Signature of Director or Instructor: _____ Date: _____

Please send this completed Verification Form together with transcript to ARCB by mail, e-mail or fax (details above).

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SCHOOL VERIFICATION FORM
Hand Reflexology Education

School Director/Instructor:

As a part of the application process to take the ARCB national certification examination, the student that has provided you this form is required to have you verify his / her **hand** reflexology education below and return the form directly to ARCB.

School and Student Information:

Name of School or Program: _____

If your program keeps actual transcript records, please enclose a copy with this form.

Student's name _____

Month/Year Study began: _____ Month/Year Study completed: _____

Verification of Instructional Hours:

I / We verify that the student named above has completed the following hours of instruction:

Total Hours devoted to hand reflexology: _____

- Total number of **in-classroom** instructional hours devoted to hand reflexology: _____
- Total number of **practical (hands on) in-classroom** hours devoted to hand reflexology: _____

Individual subject hours taught:

- Reflexology theory specific to hand reflexology: _____
- Anatomy and physiology specifically focused on study of the arm and hand: _____
- Hand reflexology technique: _____
- Pathology / contraindications specific to the arm and hand: _____
- Other (please specify): _____

The training was: ☐ Hand Reflexology only ☐ Overall Reflexology Program including Hand and Foot

Hand Reflexology Program completed? ☐Yes ☐No

Overall Reflexology Program completed? ☐Yes ☐No

Certification granted? ☐Yes ☐No Date of certification: _____

Name of Reflexology Instructor: _____

Signature of Director or Instructor: _____ Date: _____

Please send this completed Verification Form together with transcript to ARCB by mail, e-mail or fax (details above).