ACA council on Chiropractic Pediatrics

Helping chiropractors guide today's children toward a healthier tomorrow

Please Note: ACA membership is required for membership in the ACA Pediatrics Council. By completing and signing this application, the applicant supports and fosters the tenets and objectives of the ACA. It is also understood that lack of support and fostering the tenets of the ACA will lead to denial or revocation of membership.

Membership Application

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: *H:* _____ *W:* _____

M: _____ *Fax:* _____

Email: _____

Chiropractic/Medical School: _____

States of Current Licensure: _____

Membership Type *(corresponds to ACA Membership Categories, except *)*:

___ DC Physician *($85)*
___ Student Member - *Free*
___ New Graduate
(1st year of practice)
___ New Practitioner
(2nd-4th years post-graduation)
___ CA Member- *Free*
___ International Member
(DC practicing outside the U.S)
___ *Supporting Member
(Non-DC practitioner supporting pediatric chiropractic care)

___ Family Member
(DC with immediate family in the same office)
___ Retired/Disabled Member
(DC no longer in active practice)
___ Life Member
(DC over 70 years old, ACA member for > 10 years)
___ Sustaining Member
(DC, semi-retired, working <20 hours/week)
___ Associate Member
(non-practicing DC d/t college or military)

Total yearly dues: _____
(from membership type above)

To better meet your needs, we would appreciate your answers to the following questions:

Board Certifications *(attach curriculum vitae)*

___ Pediatrics
___ Family Practice/ Internal Medicine
___ Orthopedics
___ Occupational Health
___ Sports Medicine
___ Neurology
___ Nutrition
___ Radiology
___ Physiological Therapeutics
___ Other:

Practice

___ Private Practice
___ Outpatient Clinic
___ Faculty/ Teaching Clinic
___ HMO
___ Occupational/ Rehabilitative Medicine
___ Preventive Medicine/ Wellness
___ Chinese Medicine
___ Acupuncture
___ Naturopathic Medicine
___ Manual Medicine
___ Group Practice
___ Other:

Please accept my additional contribution of: _____
to further the work of the council.

Total Payment: _____

Forward Application & Payment to:
ACA Membership & Specialty Councils
1701 Clarendon Blvd/ Arlington, VA 22209
Or fax to: 703-243-2593

CC #: _____

Exp Date: _____ CCV:_____

Billing Zip Code: _____

Signature _____

Date _____

ACA www.acapedscouncil.org