Your Hands On Partner™

Membership Application

(Please Print)

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Name ____

Address ____

City ______________________ State __________ Zip ______________

Phone: H( ) ____________ W( ) ____________ FAX( ) ________________

E-Mail: ____

Chiropractic / Medical School ______________________________

States of Current Licensure ______________________________

Membership Type

__ DC Physician member* - $85
__ Student Member– Free
__ New Graduate (*1st year of practice*) – Free

** including new practitioner, international, supporting, life, sustaining, retired/disabled, and associate member types of ACA general membership)*

Total yearly dues: _____

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

Board Certifications*

__ Radiology
__ Family Practice / Internal Medicine
__ Orthopedics
__ Occupational Health
__ Sports Medicine
__ Neurology
__ Nutrition
__ Behavioral Health
__ Physiological Therapeutics
__ Other ______________

Practice

__ Private Practice
__ Outpatient Clinic
__ Faculty / Teaching Clinic
__ Health Maintenance Organization
__ Occupational / Rehabilitative Medicine
__ Preventive Medicine / Wellness
__ Oriental Medicine
__ Acupuncture
__ Multi-Disciplinary
__ Manual Medicine
__ Group Practice
__ Other ____________

Please accept my additional contribution of_________ to further the work of the Council

Total Payment _______

Make checks payable to: ACA – Council on Chiropractic Pediatrics

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 _________