

# Membership Application



Doctor's Name \_\_\_\_\_

Student's Name \_\_\_\_\_ College \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ Email \_\_\_\_\_

Date of Birth \_\_\_\_\_ Chiropractic college of graduation (for DCs) \_\_\_\_\_

Date of graduation \_\_\_\_\_

Other degrees/Where obtained \_\_\_\_\_

National and state chiropractic association(s) to which you belong \_\_\_\_\_

Chiropractic License # \_\_\_\_\_ State \_\_\_\_\_

License # \_\_\_\_\_ State \_\_\_\_\_

License # \_\_\_\_\_ State \_\_\_\_\_

Engaged in active practice?  Yes  No

ICA Council on Chiropractic Philosophy — Dues Structure	
■ <b>Application Fee</b> (one-time assessment)	\$ 15.00
■ <b>Dues*</b> (DC \$120/calendar year; Student \$25/calendar year)	\$ _____
*Pro-rated DC dues are \$10/month. Please start with the month you join and calculate the amount through the end of the calendar year.	
	TOTAL: \$ _____

I hereby apply for membership in the Council on Chiropractic Philosophy of the International Chiropractors Association.  
I understand that failure to remit dues will result in loss of membership, and all rights and privileges thereof.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

Enclosed is my check for \$ \_\_\_\_\_ Please charge my:  Visa  MasterCard  American Express

Account # \_\_\_\_\_ Expiration date \_\_\_\_\_

Return application with check or credit card information to:

**ICA Council on Chiropractic Philosophy**  
1110 N. Glebe Road, Suite 650, Arlington, VA 22201



**Fax to: 703-351-7893**