



MEMBERSHIP APPLICATION FORM

ICA COUNCIL ON CHIROPRACTIC PEDIATRICS

Doctor's Name _____

Office Address _____

City _____ State/Province/Country _____

Zip/Country Code _____ Date of Birth _____

Phone Number _____ Fax Number _____

Chiropractic College of Graduation _____

Date of Graduation _____ Other degrees/Where obtained _____

E-mail _____

National/State Chiropractic Association(s) to which you belong _____

Chiropractic License # _____ State _____

Chiropractic License # _____ State _____

Chiropractic License # _____ State _____

Application fee (*one time assessment*) \$ 15

Dues (US \$180 calendar year)
Prorated dues are US \$15 a month. Start with the month you are joining and calculate through till December.

Dues include *JCCP* and *Chiropractic Pediatrics* magazine.

TOTAL \$ _____

PAYMENT BY:

M.O./Check Mastercard/Visa AmEx

Credit card # _____

Exp date _____ Security Code _____

Signature _____

RETURN APPLICATION TO:

**ICA Council on
Chiropractic Pediatrics**
1110 N. Glebe Road,
Suite 650
Arlington, VA 22201 USA
or fax to 703-351-7893

