

# Application for Governors' Advisory Cabinet Membership

American Chiropractic Association



## Applicant Information

- I am an ACA member, please UPGRADE my membership  
 I am a new member please sign me up

Name \_\_\_\_\_ Referred by \_\_\_\_\_  
First Middle Initial Last Optional

Home Address \_\_\_\_\_  
Street Suite/Apt # City State Zip

Office Address \_\_\_\_\_  
Street Suite/Apt # City State Zip

Office Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

E-mail \_\_\_\_\_ Chiropractic College \_\_\_\_\_ Degree \_\_\_\_\_ Grad. Date \_\_\_\_\_  
For ACA communications only

Governors' Advisory Cabinet membership dues:	Annual Dues <b>\$1,200*</b>	Monthly EZ Pay Dues <b>\$100*</b>
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## Payment Options

- Check enclosed  
 Charge Annual dues to my credit card \_\_\_\_ Visa \_\_\_\_ MasterCard \_\_\_\_ American Express \_\_\_\_ Discover

Card # \_\_\_\_\_ Expiration Date \_\_\_\_\_

Signature \_\_\_\_\_

Monthly EZ PAY options:

1. Charge my credit card monthly for \$100 (1/12 of the annual dues amount). Complete credit card information above.  
 2. Debit my checking account each month for 1/12 the annual dues amount.

Bank Name \_\_\_\_\_

Checking Account Number \_\_\_\_\_ ABA Routing Number \_\_\_\_\_

Be sure to include a sample voided check with this signed authorization.

I hereby authorize the American Chiropractic Association to initiate on or about the 15<sup>th</sup> of each month, debit entries to my credit card or checking account as indicated above and on the attached voided check. I hereby authorize the depository institution named above to debit the same from my account. Said debits shall be for the amount of my monthly dues payments. I understand that the amount will be adjusted by ACA if I change my ACA membership classification. This agreement will remain in effect unless I notify ACA, in writing, to cancel it.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Membership application is subject to review and approval by ACA's Membership Committee. In 2005, 94 percent of ACA membership dues may be deducted as an ordinary and necessary business expense. In applying for membership, I certify that I am registered and/or licensed. I understand that my application is subject to ACA Board approval, that I will be notified of its action, that failure to remit will result in loss of membership, and that membership includes all rights and privileges as provided in ACA Bylaws. I pledge to ascribe to ACA's profound commitment to top quality care, professionalism, and ethics. I respect the unique individuality of my patients and am dedicated to protecting and preserving their rights.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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