



American
Chiropractic
Association

MEMBERSHIP RENEWAL FORM

Reinstatement

Current Member Dues Payment

Category Change indicate NEW category below

_____		_____	
ACA Membership ID		Membership Category	

First	Middle	Last	Suffix
<input type="checkbox"/> Address Update (note new address below if changed)			

Clinic Name			

Address		Ste/Apt	

City	State	Zip	
_____		_____	
(_____) _____	(_____) _____		
Phone	Fax		

E-Mail (For ACA Communications only)			

Annual Dues \$ _____

Additional Contributions

NCLAF \$ _____
 PAC \$ _____
 ACF \$ _____

Total Amount \$

Payment Information (U.S. Funds Only)

<input type="checkbox"/> Pay in Full	<input type="checkbox"/> EZ PAY * (Account Debit Program)
<input type="checkbox"/> Checking	<input type="checkbox"/> Monthly
Bank Name: _____	
Account #: _____	
ABA Routing #: _____	
<input type="checkbox"/> Credit Card	<input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually
Name on card: _____	
Card #: _____	
Exp Date: _____ Security Code: _____ Amt. to Charge: _____	
Credit Card Billing Address (As if appears on your monthly statement):	
Street Address: _____	
City: _____ State: _____ Zip: _____	

Signature: _____ Date: _____

Fax form to Member Services at (703) 243-2593 or mail to ACA, 1701 Clarendon Blvd, Arlington, VA 22209
 Questions? email MemberInfo@acatoday.org or call 1-800-986-4636