



C.A. MEMBERSHIP APPLICATION

First Name	Middle Initial	Last Name	Suffix
Email (for ACA correspondence only)		Phone	Fax
Street Address		Ste #	
City	State	Zip	Date of Birth

Name of member who encouraged me to join _____

MEMBERSHIP CATEGORY	MEMBERSHIP DUES
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<input type="checkbox"/> Chiropractic Assistant- Employed by an ACA member doctor ACA membership # of member doctor: _____	\$30/year
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PAYMENT OPTIONS

- Pay in full – Check enclosed for dues
- Pay in full – Charge credit card for dues
Credit Card: Visa MasterCard Discover American Express

Full Billing Address (if different from above) _____

Name as it Appears on Card	Card Number	CVV#/CID#	Exp. Date
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ALL APPLICANTS: I certify that the information provided herein is complete and accurate. I pledge to support ACA bylaws and policies, as they are now and as they may be amended. I understand that my application is subject to ACA approval and that I will be notified of this action.

[ACA CODE: 3107]

ACA
By Mail: 1701 Clarendon Blvd., Arlington, VA, 22209
By Phone: 703.276.8800
By Fax: 703.243.2593

_____ Applicant Signature	_____ Date
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Contributions (or gifts), dues and fees to ACA are not tax deductible as charitable contributions for federal income tax purposes. To the extent that ACA does engage in lobbying activities, 94% of ACA membership dues in 2007 may be deductible as an ordinary and necessary business expense.