



FIRST NAME _____ MI _____ LAST NAME _____ SUFFIX _____

ADDRESS _____ APT./UNIT#: _____

CITY _____ STATE _____ ZIP CODE _____

HOME _____ MOBILE _____

PERMANENT EMAIL _____
(We prefer to have your personal email on file.)

CHIROPRACTIC COLLEGE _____ DATE OF GRADUATION _____

DATE OF BIRTH _____ ACA MEMBER WHO ENCOURAGED ME TO JOIN _____

1. STUDENT MEMBERSHIP

Full-time student in DC program of an accredited chiropractic college **\$60**
(covers entire enrollment plus one FREE year of membership after graduation)

Please indicate the reason(s) why you are choosing to support ACA:

- Promoting my practice
- Educational Opportunities
- Networking
- Advocacy / Legislative efforts
- Other

2. ADD SPECIALITY COUNCIL MEMBERSHIP (OPTIONAL)

ACA Specialty Councils are specialty-specific communities within ACA focused on the unique needs of your practice.

- | | | |
|--|---|---|
| <input type="checkbox"/> ACUPUNCTURE \$38 | <input type="checkbox"/> FORENSIC SCIENCES FREE | <input type="checkbox"/> PEDIATRICS FREE |
| <input type="checkbox"/> COUNCIL ON WOMEN'S HEALTH FREE | <input type="checkbox"/> NEUROLOGY \$40 | <input type="checkbox"/> PHYSIOLOGICAL THERAPEUTICS AND REHABILITATION FREE |
| <input type="checkbox"/> DIAGNOSIS AND INTERNAL DISORDERS \$40 | <input type="checkbox"/> NUTRITION \$50 | <input type="checkbox"/> SPORTS INJURIES AND PHYSICAL FITNESS \$55 |
| <input type="checkbox"/> DIAGNOSTIC IMAGING \$25 | <input type="checkbox"/> OCCUPATIONAL HEALTH FREE | |

3. DONATE TO THE ACA (OPTIONAL)

ACA PAC is the only political action committee dedicated to electing pro-chiropractic members to the US House and Senate. Only personal funds allowed. Contributions are not tax deductible.

SUGGESTED CONTRIBUTION

MONTHLY CONTRIBUTION	ANNUAL CONTRIBUTION
<input type="checkbox"/> \$10	<input type="checkbox"/> \$120
<input type="checkbox"/> other amount: _____	<input type="checkbox"/> other amount: _____



STUDENT AMERICAN
CHIROPRACTIC
ASSOCIATION

MEMBERSHIP APPLICATION

The future of chiropractic is now.

4. PAYMENT

- CHECK ENCLOSED MADE OUT TO THE AMERICAN CHIROPRACTIC ASSOCIATION.
- CHARGE MY CREDIT CARD

NAME AS IT APPEARS ON ACCOUNT: _____

CREDIT/DEBIT #: _____ SECURITY CODE: _____ EXPIRATION DATE: _____

AMOUNT TO CHARGE: _____ SIGNATURE: _____

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.

PLEDGE OF PROFESSIONAL VALUES: I certify that I have read the ACA Pledge of Professional Values and pledge to abide by it.
www.acatoday.org/Join/Pledge

SIGNATURE OF APPLICANT: _____ DATE: _____



AMERICAN
CHIROPRACTIC
ASSOCIATION

RETURN APPLICATION TO:

American Chiropractic Association
1701 Clarendon Blvd., Suite 200
Arlington, VA 22209

Phone: 703-276-8800 | Fax: 703-243-2593
memberinfo@acatoday.org | www.acatoday.org



acaatoday.org/join