AMERICAN CHIROPRACTIC ASSOCIATION

STATE AFFILIATION APPLICATION

The below-named state organization is hereby applying for formal affiliation status with the ACA.

Contact Information: *Please type or print. Please complete application in its entirety.*

Date:

STATE ORGANIZATION INFORMATION:			
Organization Name:			
Address:		Fed Tax ID:#:	
		Incorporation Date:	
City:	State:	Zip:	County:
Website:			
ED / CEO:			
Email:			
Phone:		Fax:	
Total Membership:			
Are you a member of ACA? ☐Yes ☐No		What level of membership would this be?	
ACA State Delegate:		Is he/she a voting member of your state organization board/governing body?	
ACA State Alternate Delegate:		Is he/she a voting member of your state organization board/governing body?	
ACA CAC Representative:		Is he/she a voting member of your state organization board/governing body?	
RECOMMENDATION FOR STATE ORGANIZATION REPRESENTATIVE TO ACA:			
Name of State Representative:		Is he / she currently a voting member of your state organization?	
Address:		Board Title:	
		Is he / she a current member of the ACA? No. of Years a member?	
City:	State:	# of years in practice?	
Zip:	County:	Is he/she your state delegate?	
Email:		What is this person's past experience in state organization leadership?	
Phone:			
Fax:			

By signing the Application for Affiliation, we here by agree to (1) abide by the ACA by-laws, and (2) certify that the information provided is accurate and that the person recommended for state representative meets the following requirements: 1) is licensed to practice Chiropractic in the State applying for affiliation status; 2) his or her license to practice chiropractic is not presently inactive, suspended or revoked; 3) is currently a member in good standing of both the state applying for affiliation status and of the ACA; 4) is not in violation of any provision of the your state organization's By-laws, Articles of Incorporation and / or Policy; and 5) has never pleaded guilty, entered a plea of nolo contender, or has been found guilty by a judge or jury of a felony. If any of the information provided by Applicant is inaccurate, the Applicant agrees and understands that the ACA has the right to revoke Applicant's membership pursuant to the ACA Bylaws.

Internal Use Only:

Received by: _____ **Date:** _____

Approved by HOD Date: _____ **New Member Orientation:** _____

REPLY TO: American Chiropractic Association | 1701 Clarendon Blvd, Arlington, VA 22209 | Phone: 703-276-8800 | Fax: 703-243-2593