



# Council Membership Application

(Please Print)

To join the ACA Council on Chiropractic Pediatrics, you must be an ACA member in good standing.

Invoice Date: \_\_\_\_\_ Due Date: \_\_\_\_\_

ACA Membership ID Number (Required): \_\_\_\_\_

Full Name: \_\_\_\_\_

Practice/Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Phone Number: Home/Mobile (\_\_\_\_)\_\_\_\_-\_\_\_\_ Work (\_\_\_\_)\_\_\_\_-\_\_\_\_ Fax (\_\_\_\_)\_\_\_\_-\_\_\_\_

Email Address: \_\_\_\_\_

Chiropractic/Medical School: \_\_\_\_\_

State of Current Licensure: \_\_\_\_\_

### Board Certifications

- Radiology
- Family Practice / Internal Medicine
- Orthopedics
- Occupational Health
- Sports Medicine
- Neurology
- Nutrition
- Behavioral Health
- Physiological Therapeutics
- Other

### Practice

- Private Practice
- Outpatient Clinic
- Faculty / Teaching Clinic
- Health Maintenance Organization
- Occupational / Rehabilitative Medicine
- Preventative Medicine / Wellness
- Oriental Medicine
- Acupuncture
- Multi-Disciplinary
- Manual Medicine
- Group Practice
- Other

### Membership Category

- DC Physician Member\*: \$85
- Student Membership: FREE
- New Graduate (1st year of practice): FREE

\*including new practitioner, international, supporting, life, sustaining, retired-disabled, and association member types of ACA general membership

If paying by check, please make payable to ACA – Council on Chiropractic Pediatrics at the attention of the ACA Director of Component Relations. You can submit your application by mail, phone (703-812-0209), or fax (703-243-2593). For your security, we ask that you refrain from emailing financial information. If you have questions, contact [pedsCouncil@acatoday.org](mailto:pedsCouncil@acatoday.org) or visit <http://www.acapedscouncil.org/>.

Credit Card Number: \_\_\_\_\_

Full name as it appears on your card: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Security Code: \_\_\_\_\_

Billing Zip Code: \_\_\_\_\_

I certify that the information provided herein is complete and accurate. I agree to support the bylaws of ACA and ACA Council on Chiropractic Pediatrics now and as they may be amended. I understand that my application is subject to ACA approval and I will be notified of this action.

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