COUNCIL ON WOMEN'S HEALTH

Your Hands On Partner™

Council Membership Application

(Please Print)

To join the ACA Council on Women's Health, you must be an ACA member in good standing.

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: _____

Your Council on Women's Health membership renewal date will coincide with your ACA membership.

Membership Category

- ☐ General Membership: $80.00
- ☐ Student Membership: FREE

If paying by check, please make payable to ACA – Council on Women's Health 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, email WomensCouncil@acatoday.org or visit acatoday.org/womenshealth.

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 Women's Health 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: _____

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