



FIRST NAME: _____ MI: _____ LAST NAME: _____ SUFFIX: _____ DEGREES: _____

CLINIC NAME (if applicable): _____ WEBSITE: _____

ADDRESS: _____ APT./UNIT #: _____ DATE OF BIRTH: _____

CITY: _____ STATE: _____ DATE OF GRADUATION: _____

ZIP CODE: _____ COUNTRY: _____ CHIROPRACTIC COLLEGE: _____

SHOW ADDRESS IN ONLINE SEARCH? YES NO IS ADDRESS? WORK HOME

WORK PHONE: _____ MOBILE: _____ EMAIL: _____

FAX: _____ ENCOURAGED TO JOIN BY: _____

1. TYPE OF MEMBERSHIP (SELECT ONE)	MONTHLY DUES	ANNUAL DUES
<input type="checkbox"/> GENERAL MEMBER	\$55	\$660
<input type="checkbox"/> FAMILY Name of Member: _____	\$27.50	\$330
<input type="checkbox"/> STUDENT	\$60 (one time fee)	
<input type="checkbox"/> NEW GRADUATE	FREE (first year)	
<input type="checkbox"/> NEW PRACTITIONER		
<input type="checkbox"/> 2nd year after graduation	\$11	\$132
<input type="checkbox"/> 3rd year after graduation	\$22	\$264
<input type="checkbox"/> 4th year after graduation	\$33	\$396
<input type="checkbox"/> 5th year after graduation	\$44	\$528
<input type="checkbox"/> SUSTAINING Practicing DCs working (check one)		
<input type="checkbox"/> Part-time <input type="checkbox"/> Faculty <input type="checkbox"/> Military/VA	\$27.50	\$330
<input type="checkbox"/> ASSOCIATE Non-practicing licensed DC or non-DC		
<input type="checkbox"/> Faculty member at a chiropractic college <input type="checkbox"/> Currently serving in the U.S. armed forces <input type="checkbox"/> Other: _____	\$14	\$165
<input type="checkbox"/> RETIRED/DISABLED	\$11	\$132
<input type="checkbox"/> INTERNATIONAL	\$14	\$165
<input type="checkbox"/> GOVERNORS' ADVISORY CABINET (GAC)	\$100	\$1200

2. ADD SPECIALTY COUNCIL MEMBERSHIP (OPTIONAL)

ACA Specialty Councils are specialty-specific communities within ACA focused on the unique needs of your practice. Specialty Council dues are billed yearly and will not be included in EZ Pay.

- | | | |
|---|---|--|
| <input type="checkbox"/> ACUPUNCTURE \$145 | <input type="checkbox"/> FORENSIC SCIENCES \$150 | <input type="checkbox"/> OCCUPATIONAL HEALTH \$80 |
| <input type="checkbox"/> WOMEN'S HEALTH \$80 | <input type="checkbox"/> NEUROLOGY \$115 | <input type="checkbox"/> PHYSIOLOGICAL THERAPEUTICS AND REHABILITATION \$130 |
| <input type="checkbox"/> DIAGNOSTIC IMAGING \$150 | <input type="checkbox"/> NUTRITION \$150 | <input type="checkbox"/> SPORTS INJURIES AND PHYSICAL FITNESS \$150 |
| <input type="checkbox"/> PEDIATRICS \$85 | <input type="checkbox"/> DIAGNOSIS AND INTERNAL DISORDERS \$120 | |
| <input type="checkbox"/> ORTHOPEDICS \$100 | | |

3. DONATE TO ACA (OPTIONAL)

MONTHLY CONTRIBUTION

ANNUAL CONTRIBUTION

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

\$10
 other amount: _____

\$120
 other amount: _____

NCLAF
The National Chiropractic Legal Action Fund is used to help fund lawsuits that threaten freedom of choice and access to healthcare. Contributions are not tax deductible.

\$10
 other amount: _____

\$120
 other amount: _____

ACF
The American Chiropractic Foundation furthers the mission of DCs, emphasizing the importance of education, research, and awareness. Contributions are tax deductible.

\$10
 other amount: _____

\$120
 other amount: _____

4. PAYMENT

PAY IN FULL - please enclose a check made out to the American Chiropractic Association or complete the credit card section below.

EZ PAY - EZPay - monthly auto-drafts from authorized credit card or checking account

NAME AS IT APPEARS ON ACCOUNT: _____

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

FOR BANK DRAFT

CHECKING ACCOUNT #: _____ ROUTING #: _____

NAME OF BANK: _____

AMOUNT TO CHARGE: _____ SIGNATURE: _____

EZ PAY APPLICANTS: I authorize ACA to initiate on or about the 11th of each month debit entries to my credit card or bank account. I understand 1/12 of the annual membership dues will be charged to my designated account and that monthly payments are not refundable. I understand the amount will change if there are changes to my ACA membership category or dues. This agreement will remain in effect unless I notify ACA in writing to cancel it. Cancellations will not be accepted during the first 12 months of membership.

DOCTOR APPLICANTS: I certify that I'm currently a Doctor of Chiropractic. I certify that I have read the ACA code of Ethics and pledge to abide by it.

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

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.

SIGNATURE OF APPLICANT: _____ DATE: _____

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 engages in lobbying activities, 87% of ACA membership dues in 2022/2023 may be deductible as an ordinary and necessary business expense.

REFUND POLICY

Memberships are 12 months and renew on each anniversary date. Requests for membership cancellation and dues refunds must be made in writing to memberinfo@acatoday.org, subject line "Membership Dues Refund Request", within 30 days of receipt of payment for full dues only. Requests received after 30 days are not eligible for refund or cancellation. Monthly installment payments are not eligible for refunds. Dues waivers for hardship must be submitted to state delegate for consideration. Specialty council membership cancellation and refunds must be submitted directly to the council.



RETURN APPLICATION TO:

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

QUESTIONS?

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