



# Council Membership Application

(Please Print)

To join the ACA Council on Nutrition, 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(s) of Current Licensure: \_\_\_\_\_

## Membership Category

General Membership: \$150

Student Membership: \$50

If paying by check, please make payable to ACA - Council on Nutrition at the attention of the ACA 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 [bclifton@acatoday.org](mailto:bclifton@acatoday.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 Nutrition 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: \_\_\_\_\_