MCA Membership Application



City	Full Name	Birth Date (MM/DD/YY	YY)/	
City State Zip County Years in Practice Phone Fax Email Year Graduated Chiropractic College DC Date Licensed (MM/DD/YYYY) / DC License Number Top Four Techniques Practiced: Membership Rates Practicing Doctors One Year Licensed . \$150 (or \$12.5/month) One Year Licensed . \$300 (or \$25/month) O Four Years Licensed . \$300 (or \$25/month) O Part Time DC . \$300 (or \$25/month) O Part Time DC . \$300 (or \$25/month) O Part Time DC . \$300 (or \$25/month) O Pay in Full O Monthly auto-pay (Only available to those in Practicing Doctors Categories, You MUST include credit card information below. No checks will be accepted for this option.) O Check (Payable to MCA) O VISA O MasterCard O AMEX O Discover All credit card fields are required. Card Number Exp. date Security code Cardholder Signature Credit Card Billing Address: O Same as address above Address County State Zip Thereby apply for memberalip in the Minnesota Chiropractic Association for the purpose of serving the whole chiropractic profession of the State of Minnesota and for the benefits in may receive from such a memberalip. Once approved as a memberal give to overly with the bylivos and Code of this of this Association and all precent and future regulatory measures as set forth by the Association in department of the MCA is the bridge of profession and all precent and future regulatory measures as set forth by the characterial that as a member of the MCA is the bridge of profession and all precent and future regulatory measures as set forth by the characterial that as a member of the MCA is the bridge of profession and all precent and future regulatory measures as set forth by the correct opinion, we will make the most implace when we work together respectively, joining resources, latents, and the or oreas a testic member of t	Clinic Name/Organization			
Home Address City State Zip County Years in Practice Phone Fax Email Chiropractic College DC Date Licensed (MM/DD/YYYY) /	Mailing Address			
City State Zip County Years in Practice Phone Fax Email Years in Practice Phone Fax Email Chiropractic College Year Graduated DC Date Licensed (MM/DD/YYYY) / DC License Number Top Four Techniques Practiced: Membership Rates	City	State	Zip	
County Fax Email Fax Email Chiropractic College Year Graduated DC Date Licensed (MM/DD/YYYY)/_ DC License Number				
Phone Fax Email Chiropractic College Year Graduated DC Date Licensed (MM/DD/YYYY)	City	State	Zip	
Chiropractic College DC Date Licensed (MM/DD/YYYY) DC License Number				
DC Date Licensed (MM/DD/YYYY)	Phone Fax	Email		
Membership Rates Practicing Doctors One Year Licensed				
Membership Rates Practicing Doctors One Year Licensed	DC Date Licensed (MM/DD/YYYY)/	DC License Number		
Other Memberships ○ One Year Licensed	Top Four Techniques Practiced:			
O ne Year Licensed	Membership Rates			
O Two Years Licensed	Practicing Doctors	Other Memberships		
O Three Years Licensed		O Chiropractic Assistant/Chiropractic Tech \$300		
O Four+ Years Licensed				
O Part Time DC\$300 (or \$25/month) O Out-of-State Member\$150 Student				
Payment info ○ Pay in Full ○ Monthly auto-pay (Only available to those in Practicing Doctors Categories. You MUST include credit card information below. No checks will be accepted for this option.) ○ Check (Payable to MCA) ○ VISA ○ MasterCard ○ AMEX ○ Discover All credit card fields are required. Card Number				
Payment info ○ Pay in Full ○ Monthly auto-pay (Only available to those in Practicing Doctors Categories. You MUST include credit card information below. No checks will be accepted for this option.) ○ Check (Payable to MCA) ○ VISA ○ MasterCard ○ AMEX ○ Discover All credit card fields are required. Card Number				
O Pay in Full O Monthly auto-pay (Only available to those in Practicing Doctors Categories. You MUST include credit card information below. No checks will be accepted for this option.) O Check (Payable to MCA) O VISA O MasterCard O AMEX O Discover All credit card fields are required. Card Number		O Full-time College Faculty Me	mber \$300	
Cardholder Name (print) Cardholder Phone	O Pay in Full O Monthly auto-pay (Only available to those in below. No checks will be accepted for this option.)		T include credit card information	
Cardholder Signature Credit Card Billing Address: O Same as address above Address County State Zip I hereby apply for membership in the Minnesota Chiropractic Association for the purpose of serving the whole chiropractic profession of the State of Minnesota and for the benefits I may receive from such a membership. Once approved as a member I agree to comply with the Bylaws and Code of Ethics of this Association and all present and future regulatory measures as set forth by the Association. I understand that as a member of the MCA I will be held to a high standard of professionalism and agree to work with the association in regards to its initiatives. I acknowledge that while our profession may have differences of opinion, we will make the most impact when we work together respectfully, joining resources, talents, and time to create a better, healthier world. I will embrace these differences and continue to work toward the goal of "Chiropractic for All." I understand that to remain a member and receive membership benefits (including all group insurance programs, discounts, and marketing program rights) I must maintain my dues account as current. I relinquish all my membership benefits if my dues are 30 days past due. Signature Date (MM/DD/YYYY) (For office use only) initials fin. date CK/CC amt. paid bld due	Card Number	Exp. date	Security code	
Credit Card Billing Address: O Same as address above Address County State Zip I hereby apply for membership in the Minnesota Chiropractic Association for the purpose of serving the whole chiropractic profession of the State of Minnesota and for the benefits I may receive from such a membership. Once approved as a member I agree to comply with the Bylaws and Code of Ethics of this Association and all present and future regulatory measures as set forth by the Association. I understand that as a member of the MCA I will be held to a high standard of professionalism and agree to work with the association in regards to its initiatives. I acknowledge that while our profession may have differences of opinion, we will make the most impact when we work together respectfully, joining resources, talents, and time to create a better, healthier world. I will embrace these differences and continue to work toward the goal of "Chiropractic for All." I understand that to remain a member and receive membership benefits (including all group insurance programs, discounts, and marketing program rights) I must maintain my dues account as current. I relinquish all my membership benefits if my dues are 30 days past due. Signature Date (MM/DD/YYYY) (For office use only) initials fin. date CK/CC ant. paid bal due	Cardholder Name (print)	Cardholder Phone		
Address	Cardholder Signature			
I hereby apply for membership in the Minnesota Chiropractic Association for the purpose of serving the whole chiropractic profession of the State of Minnesota and for the benefits I may receive from such a membership. Once approved as a member I agree to comply with the Bylaws and Code of Ethics of this Association and all present and future regulatory measures as set forth by the Association. I understand that as a member of the MCA I will be held to a high standard of professionalism and agree to work with the association in regards to its initiatives. I acknowledge that while our profession may have differences of opinion, we will make the most impact when we work together respectfully, joining resources, talents, and time to create a better, healthier world. I will embrace these differences and continue to work toward the goal of "Chiropractic for All." I understand that to remain a member and receive membership benefits (including all group insurance programs, discounts, and marketing program rights) I must maintain my dues account as current. I relinquish all my membership benefits if my dues are 30 days past due. Signature Date (MM/DD/YYYY)	Credit Card Billing Address: O Same as address above			
I hereby apply for membership in the Minnesota Chiropractic Association for the purpose of serving the whole chiropractic profession of the State of Minnesota and for the benefits I may receive from such a membership. Once approved as a member I agree to comply with the Bylaws and Code of Ethics of this Association and all present and future regulatory measures as set forth by the Association. I understand that as a member of the MCA I will be held to a high standard of professionalism and agree to work with the association in regards to its initiatives. I acknowledge that while our profession may have differences of opinion, we will make the most impact when we work together respectfully, joining resources, talents, and time to create a better, healthier world. I will embrace these differences and continue to work toward the goal of "Chiropractic for All." I understand that to remain a member and receive membership benefits (including all group insurance programs, discounts, and marketing program rights) I must maintain my dues account as current. I relinquish all my membership benefits if my dues are 30 days past due. Signature Date (MM/DD/YYYY)	Address	-		
for the benefits I may receive from such a membership. Once approved as a member I agree to comply with the Bylaws and Code of Ethics of this Association and all present and future regulatory measures as set forth by the Association. I understand that as a member of the MCA I will be held to a high standard of professionalism and agree to work with the association in regards to its initiatives. I acknowledge that while our profession may have differences of opinion, we will make the most impact when we work together respectfully, joining resources, talents, and time to create a better, healthier world. I will embrace these differences and continue to work toward the goal of "Chiropractic for All." I understand that to remain a member and receive membership benefits (including all group insurance programs, discounts, and marketing program rights) I must maintain my dues account as current. I relinquish all my membership benefits if my dues are 30 days past due. Signature Date (MM/DD/YYYY)/	City	State	Zip	
Send your completed registration form and payment to: MCA • 1360 University Ave W, Ste 104-125 initials fin. date CK/CC amt. paid	for the benefits I may receive from such a membership. Once approved as a membership and future regulatory measures as set forth by the Association. I understand agree to work with the association in regards to its initiatives. I acknowledg impact when we work together respectfully, joining resources, talents, and time to work toward the goal of "Chiropractic for All." I understand that to remain a second control of the co	mber I agree to comply with the Bylaws and Co stand that as a member of the MCA I will be he e that while our profession may have difference to create a better, healthier world. I will embra member and receive membership benefits (incl	ode of Ethics of this Association and all ld to a high standard of professionalism es of opinion, we will make the most ace these differences and continue luding all group insurance programs,	
Send your completed registration form and payment to: MCA • 1360 University Ave W, Ste 104-125	Signature Date (M	M/DD/YYYY) / /	(For office use only)	
Send your completed registration form and payment to: MCA • 1360 University Ave W, Ste 104-125 ant. paid			initials fin.	
MCA • 1360 University Ave W, Ste 104-125	Send your completed registration form and p	avment to:		
hald due		,		