MCA Membership Application

Full Name _____ Birth Date (MM/DD/YYYY) _____/_____/_____
Clinic Name/Organization _____
Mailing Address _____
City _____ State _____ Zip _____
Home Address _____
City _____ State _____ Zip _____
County _____ 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

Practicing Doctors

- ☐ One Year Licensed . . . . . Free
- ☐ Two Years Licensed . . . . . $150 (or $12.5/month)
- ☐ Three Years Licensed . . . . . $300 (or $25/month)
- ☐ Four+ Years Licensed . . . . . $480 (or $40/month)
- ☐ Part Time DC . . . . . $300 (or $25/month)

Other Memberships

- ☐ Chiropractic Assistant/Chiropractic Tech . . . . . $300 . . . . . (Or included FREE with MCA DC membership)
- ☐ Non-Practicing DC Member $150
- ☐ Retiree $150
- ☐ Out-of-State Member $150
- ☐ Student . . . . . Free to all chiropractic students
- ☐ Full-time College Faculty Member $300

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 _____ Exp. date _____ Security code _____
Cardholder Name (print) _____ Cardholder Phone _____
Cardholder Signature _____
Credit Card Billing Address: ☐ Same as address above
Address _____ County _____
City _____ 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		
bal. due		

Send your completed registration form and payment to:

MCA • 1360 University Ave W, Ste 104-125
St. Paul, MN 55104