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)
- ❍ Practice Relief (Part Time Dr.) ..... $300 (or $25/month)

Other Memberships

- ❍ Chiropractic Assistant/Chiropractic Tech .... $300 (or included with membership of a DC in your clinic)
- ❍ 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 • 1000 Westgate Drive, Suite 252
St. Paul, MN 55114 • or fax to 651-290-2266