

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 • 1000 Westgate Drive, Suite 252
 St. Paul, MN 55114 • or fax to 651-290-2266