ICA COUNCIL ON UPPER CERVICAL CARE

DC MEMBERSHIP APPLICATION

Full Name: _____

Office Address: _____ City: _____

State/Province: _____ Zip/Postal Code: _____ Country: _____

Chiropractic College of graduation:_____ Year: _____

Phone number: _____ Fax number: _____

Email address:_____ Alt Email: _____

Are you in active practice? [ ] YES [ ] NO

Chiropractic License # _____ State _____

Chiropractic License # _____ State _____

OTHER CREDENTIALS/DEGREES

Technique/Procedure Certification: _____

Obtained from: _____

Other Degrees/Certifications: _____

Obtained from: _____

National and/or state organizations to which you belong: _____

MEMBERSHIP DUES

Annual dues per calendar year (January - December): $286.00

TOTAL AMOUNT: $286.00

PAYMENT INFORMATION

I am paying by: [ ] Check [ ] Mastercard/Visa [ ] American Ex [ ] Discover

Credit Card Number _____ Exp date _____ Sec Code _____

Your signature _____ Date _____

Return application with payment to:

ICA Council on Upper Cervical Care
6400 Arlington Blvd., Suite 650
Falls Church, VA 22042

or fax to 1-703-351-7893

Please call with any questions:

1-703-528-5000