



# ARKANSAS CHIROPRACTIC ASSOCIATION

## 2005 MEMBERSHIP APPLICATION

Remit by FEBRUARY 27 to be included in the 2005 Arkansas Chiropractic Directory

Name: \_\_\_\_\_

Business Name: \_\_\_\_\_

Business Address: (Physical or P.O. Box - Not Both) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Business Phone: ( ) \_\_\_\_\_ Business Fax: ( ) \_\_\_\_\_

Email: \_\_\_\_\_ Web Site: \_\_\_\_\_

Home Address: (Physical or P.O. Box - Not Both) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Chiropractic College: \_\_\_\_\_ Graduation Year: \_\_\_\_\_

License Number: \_\_\_\_\_ License Year: \_\_\_\_\_

Other States' Licenses Held: \_\_\_\_\_

Other Degrees/Certifications: \_\_\_\_\_

Are you now or have you ever been subject to a disciplinary action, membership/license suspension, or membership/license revocation by a chiropractic association or licensing board? \_\_\_\_\_ If yes, please explain on a separate sheet of paper and enclose.

Membership Agreement: I hereby apply for membership in the Arkansas Chiropractic Association. I agree to abide by the constitution and bylaws, code of ethics, and all amendments, regulations, and motions adopted by the membership of the board of directors. It is mutually agreed that this application, when accepted, shall constitute the full contract between the ACA and its members. I understand that failure to remit dues will result in loss of membership and all rights and privileges thereof.

A portion of ACA membership dues may be deducted as a business expense for federal income tax purposes. Sixty- two percent (62%) is spent on government affairs and is not tax deductible.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

_____ \$ 400 - FULL Membership	_____ \$ 15 - Student Membership
_____ \$ 50 - New Graduate (1st Year Practice)	_____ COMP - Life Membership (80 Yrs or older)
_____ \$ 200 - New Graduate (2 <sup>nd</sup> Year Practice)	_____ \$ 50 - Out Of State Membership

**PAYMENT METHOD:**

Check Enclosed - Check # \_\_\_\_\_

Bill My Credit Card

Bill Me:

\_\_\_ Semi-Annually \_\_\_ Quarterly \_\_\_ \$40 monthly for 10 months

**Credit Card Information (VISA or Mastercard Only)**

CC# \_\_\_\_\_

Type of Card: \_\_\_\_\_

Name on Card: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

**Mail this signed application to: Arkansas Chiropractic Association  
813 West 3rd Street  
Little Rock, AR 72201**

**For Questions: Phone: (501) 244-0555 Fax: (501) 244-2333  
Email: aca@arkchiro.com**