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 (Jan- December): $168.

TOTAL AMOUNT $168

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 800 ♦ Falls Church ♦ VA 22042

or **FAX to 1-703-351-7893**. Phone: 1-571-765-7554 or 1-800-423-4690 (US & Canada)