

American Academy of Chiropractic Physicians Membership Application

(Please Print)

Name _____

Address _____

City _____ State _____ Zip _____

Phone: H _____ W _____ Fax _____ E-Mail _____

Chiropractic / Medical School _____ States of Current Licensure _____

To better meet your needs, we would appreciate your answers to the following:
How did you learn about the AACP? _____

Board Certifications, if applicable

- | | |
|--------------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Radiology | <input type="checkbox"/> Neurology |
| <input type="checkbox"/> Family Practice / Internal Medicine | <input type="checkbox"/> Nutrition |
| <input type="checkbox"/> Orthopedics | <input type="checkbox"/> Behavioral Health |
| <input type="checkbox"/> Occupational Health | <input type="checkbox"/> Physiological Therapeutics |
| <input type="checkbox"/> Sports Medicine | <input type="checkbox"/> Other _____ |

Attach curriculum vitae

Practice Setting

- | | |
|----------------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Private Practice | <input type="checkbox"/> Occupational/rehabilitative medicine |
| <input type="checkbox"/> Outpatient Clinic | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> Faculty / Teaching Clinic | <input type="checkbox"/> Multi-Disciplinary |
| <input type="checkbox"/> Health Maintenance Organization | <input type="checkbox"/> Manual Medicine |
| <input type="checkbox"/> Oriental Medicine | <input type="checkbox"/> Group Practice |
| <input type="checkbox"/> Preventive Medicine / Wellness | <input type="checkbox"/> Other _____ |

Membership Type (Fiscal Year of July 01 to June 30)

- | | |
|----------------------------------------------------------------------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Member (DC, DO, MD) - \$150 | <input type="checkbox"/> Student Member - \$35 |
| <input type="checkbox"/> College Member - \$500 | <input type="checkbox"/> Corporate Member - \$500 |
| <input type="checkbox"/> Associate Member (non-DC physician) - \$150 | |
| <input type="checkbox"/> Please accept my additional contribution of \$____ to further the work of the Academy | |

Credit Card # _____ Exp _____

Visa or Master Card

Make checks payable to: AACP - American Academy of Chiropractic Physicians
Mrs. Tracy McHugh
200 E Roosevelt Rd
Lombard, IL 60148

By completing and signing this application for membership, the applicant supports and fosters the tenets and purposes of AACP and acknowledges that the Journal of Chiropractic Medicine will be received as a membership benefit. It is also understood that lack of support and fostering of the tenets and purposes of AACP will lead to denial or revocation of membership.

Signature: _____ Date: _____