

# MONTANA CHIROPRACTIC ASSOCIATION ♦ MEMBERSHIP APPLICATION

## ■ APPLICANT INFORMATION

Name: \_\_\_\_\_ MT License #: \_\_\_\_\_  
Practice Name: \_\_\_\_\_  
Office Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Office Telephone: \_\_\_\_\_ Office Fax: \_\_\_\_\_  
E-mail: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Mailing Address (if different): \_\_\_\_\_  
Second Office Location: \_\_\_\_\_

## ■ EDUCATION & LICENSES

Chiropractic College: \_\_\_\_\_ Graduation Date: \_\_\_\_\_  
Advanced Degrees, Designations, Certifications: \_\_\_\_\_  
Have you ever had a complaint filed against you?  YES  NO (If "YES," complete next line)  
Explain in detail final resolution, disciplinary action taken, or other information on conclusion of  
complaint: \_\_\_\_\_  
Other state licenses (include license #): \_\_\_\_\_

## ■ HOME INFORMATION

Home Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Spouse Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

I declare that I will comply with the Bylaws and the Code of Ethics of the MCA. When accepted for membership, I will use my best efforts to support my fellow practitioners and the objectives of the Montana Chiropractic Association.

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

## ■ SELECT TYPE OF MEMBERSHIP

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Active - Full Membership \$450 | <input type="checkbox"/> Husband/Wife \$625                  | <input type="checkbox"/> Retired \$50              |
| <input type="checkbox"/> 1st Year Member \$100          | <input type="checkbox"/> Part-time Practice (1-2 days) \$175 | <input type="checkbox"/> Inactive \$50             |
| <input type="checkbox"/> 2nd Year Member \$200          | <input type="checkbox"/> Just graduated/Student \$75         | <input type="checkbox"/> Associate/Individual \$50 |
| <input type="checkbox"/> 3rd Year Member \$300          | <input type="checkbox"/> Out-of-State \$50                   | <input type="checkbox"/> Associate/Business \$100  |
| <input type="checkbox"/> 4th Year Member \$400          |  | <input type="checkbox"/> Associate/Corporate \$100 |

## ■ METHOD OF PAYMENT—please make checks payable to Montana Chiropractic Association

Check enclosed  Visa  MasterCard  American Express  Discover  
Card #: \_\_\_\_\_ Card Validation Code: \_\_\_\_\_ Expires: \_\_\_\_\_  
Cardholder Name (please print): \_\_\_\_\_  
Cardholder Billing Address: \_\_\_\_\_  
Cardholder Signature: \_\_\_\_\_

## ■ PLEASE RETURN FORM & PAYMENT TO:

36 South Last Chance Gulch, Suite A, Helena, MT 59601  
Phone 406.443.1160 ■ Fax 406.443.4614 ■ E-mail [sweingartner@rmsmanagement.com](mailto:sweingartner@rmsmanagement.com) ■ Web [www.mtchiro.org](http://www.mtchiro.org)