

INTERNATIONAL CHIROPRACTORS ASSOCIATION OF CALIFORNIA APPLICATION FOR MEMBERSHIP

DATE _____

NAME (Please Print or Type) - Last		First		Middle Int.	
ADDRESS <input type="checkbox"/> Office <input type="checkbox"/> Home		Suite/Apt.	City	State CA	Zip Code
EMAIL		OFFICE Telephone	CELL Phone	FAX Number	
CHIROPRACTIC LICENSE NUMBER (CA)		DATE OF CALIFORNIA LICENSE		Degree: D.C.	

DIRECT PAYMENT AUTHORIZATION and Agreement for \$39 per Month - \$100 per Year Reduction in Dues

AUTOMATIC MONTHLY DEBIT OR CREDIT CARD (\$120/YR SAVINGS OFF MONTHLY FEES)

Fourth Year Following Licensure \$ 39/Mo

METHOD OF PAYMENT

VISA Master Card American Express Discover Card Monthly Payment on: 1st day of month
Date Other: _____

I hereby authorize the International Chiropractors Association of California (ICAC) to initiate debits or credits to my debit or credit card identified above. By signing this agreement, I understand that I am receiving a \$100 per year reduction in dues, and that I authorize the ICAC to debit my account each month for \$39 and on the same date each month thereafter, until canceled as stated below.

I authorize the bank or credit card company to make payment on my behalf to the ICAC. I understand that I am in full control of my payment. I can stop this automatic direct payment at any time by writing or calling the ICAC.

I have read, understand, and agree with the terms of this form.

Signature: _____ Date: _____

AGREEMENT

I hereby agree to the ICAC Bylaws and Code of Ethics, as adopted, and as may be adopted from time to time by the ICAC Board of Directors.

APPLICANT'S SIGNATURE

X

ICAC SPONSORING MEMBER (IF APPLICABLE)
John K. Maltby, D.C., FICAC(H)

FOR OFFICE USE ONLY

Date Received	Fee Received \$
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Monthly Payments Via
 Visa Master Card American Express
 Discover Card Other:

MEMBERSHIP PACKET SENT ON	BY
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ICAC Board of Directors 1/1/2022
Phone: (916) 362-8816

Mail to:
(Fits Window Envelope)

ICAC Membership
9700 Business Park Drive, Suite # 200
Sacramento, CA 95827-1717