



Montana Chiropractic Association
 1645 Parkhill Drive, Suite 6
 Billings, MT 59102
 406-256-1005
 Fax: 406-256-0785

MEMBERSHIP APPLICATION

Doctor's Name _____
 Company Name _____
 Contact Name (front desk / office manager) _____
 Street Address _____
 Mailing Address _____
 City State Zip _____
 Office Phone _____ Fax _____
 Cell (Doctor) _____ Other _____
 Email _____ Website _____

Note: our email system will not send to addresses using 'role based' words like admin, info, office, support, sales, etc., before the @domain.com. Best practice: use some form of a person's name, nickname, initials, or company name.

College Attended (full name, please) _____
 Year Graduated _____ MT License # _____ Degrees / Certifications _____
 Certified for Impaired Rating? Yes No Other Services: _____
 Areas of Interest _____

Please indicate with a "star" any item(s) above that you wish not be published. (such as personal cell#)

**If you have additional doctors or locations, please copy this form
 and complete the information for each provider and site location.**

SELECT TYPE OF MEMBERSHIP

Active Full Membership	\$450	Husband &/Wife (\$312.50 each)	\$625	Inactive	\$ 50
1 st Year After Graduation	\$100	Part-time Practice (1-2 Days)	\$175	Non-Resident	\$ 50
2 nd Year After Graduation	\$200	Just Graduated/Student	\$ 75	Associate / Individual	\$ 50
3 rd Year After Graduation	\$300	Retired	\$ 50	Associate / Business	\$100
4 th Year After Graduation	\$400			Associate / Corporate	\$100

**METHOD OF PAYMENT: Make checks payable to Montana Chiropractic Association
 Please note our change of address. Thank you.**

_____ Check enclosed _____ Charge the full amount to my card _____ See my attached recurring charge authorization
 Card # _____ Validation Code: _____ Expiration Date ____ / ____
 Cardholder name (please print): _____
 Cardholder Billing Address, City, Zip: _____
 Cardholder Signature: _____