MCA Membership Application

Full Name _____ Birth Date (MM/DD/YYYY) ____ /____ / _____
Clinic Name/Organization _____
Mailing Address _____
City _____ State _____ Zip _____
Home Address _____
City _____ State _____ Zip _____
County _____ Years in Practice _____
Phone _____ Fax _____ Email _____
Chiropractic College _____ Year Graduated _____
DC Date Licensed (MM/DD/YYYY) ____ / ____ /_____ DC License Number _____
Top Four Techniques Practiced: _____

Membership Rates

Practicing Doctors

❍ One Year Licensed . . . . . $180 (or $15/month)
❍ Two Years Licensed . . . . . $360 (or $30/month)
❍ Three Years Licensed . . . . . $540 (or $45/month)
❍ Four+ Years Licensed . . . . . $720 (or $60/month)
❍ Practice Relief (Part Time Dr.) . . . . . $360 (or $30/month)

Other Memberships

❍ Chiropractic Assistant/Chiropractic Tech $42.25
. . . . . or included with membership of a DC in your clinic
❍ Non-Practicing DC Member $180
❍ Retiree $80
❍ Out-of-State Member $360
❍ Student . . . . . Free to all chiropractic students
❍ Full-time College Faculty Member $360

Payment info

❍ Pay in Full ❍ Monthly auto-pay (Only available to those in Practicing Doctors Categories).
You MUST include credit card information below. No checks will be accepted for this option.)

❍ Check (Payable to MCA) ❍ VISA ❍ MasterCard ❍ AMEX ❍ Discover

All credit card fields are required.

Card Number _____ Exp. date _____ 3- or 4-digit security code _____
Cardholder Name (print) _____ Cardholder Phone _____
Cardholder Signature _____
Credit Card Billing Address: ❍ Same as address above
Address _____ County _____
City _____ State _____ Zip _____

I hereby apply for membership in the Minnesota Chiropractic Association for the purpose of serving the whole chiropractic profession of the State of Minnesota and for the benefits I may receive from such a membership. Once approved as a member I agree to comply with the Bylaws and Code of Ethics of this Association and all present and future regulatory measures as set forth by the Association. I understand that as a member of the MCA I will be held to a high standard of professionalism and agree to work with the association in regards to its initiatives. I acknowledge that while our profession may have differences of opinion, we will make the most impact when we work together respectfully, joining resources, talents, and time to create a better, healthier world. I will embrace these differences and continue to work toward the goal of "Chiropractic for All." I understand that to remain a member and receive membership benefits (including all group insurance programs, discounts, and marketing program rights) I must maintain my dues account as current. I relinquish all my membership benefits if my dues are 30 days past due.

Signature _____ Date (MM/DD/YYYY) ____ /____ / _____

(For office use only)

initials		fin.
date		
CK/CC		
amt. paid		
bal. due		

Send your completed registration form and payment to:
MCA • 1000 Westgate Drive, Suite 252
St. Paul, MN 55114 • or fax to 651-290-2266