



Membership Application

To apply for membership please complete this form and submit your request to:

MCPA, P.O. Box 182529 Shelby Twp., MI 48318-2529

or fax your request to **586-726-7045**

STEP 1 Personal Information

Name: _____ Title: _____
 Street Address: _____ City: _____
 State: _____ Zip Code: _____ Phone: _____ Fax: _____ Email: _____
 Website: _____

STEP 2 Annual Membership Type

Please select the type of membership:

Certified Pediatric DC (\$1200) ** \$ _____

ICPA Webster Certified DC (\$900) ** \$ _____

Family DC (\$600) ** \$ _____

Affiliate Healthcare Practitioner (\$300) \$ _____

Public (\$40) \$ _____

Corporate Sponsor (\$500 minimum) \$ _____

Are you a member of any of the following?

ICPA (\$145 discount) - \$ _____

MAC (%10 discount) - \$ _____

HPA (%5 discount) - \$ _____

Total Dues \$ _____

STEP 3 Additional Information

Practice Name: _____

Percent of practice caring for children: _____%

Percent of practice dealing with pregnancy: _____%

Do you have postgraduate training in pediatrics?

Yes No *By whom?* _____

Are you Webster certified through the ICPA?

Yes No

Please list your local media outlets with fax numbers:

** ICPA membership is required for DC's and is included with your MCPA dues. A discount applies if you are already an ICPA member.

STEP 4 Payment Options

Please select your payment option: Payment in Full 4 Quarterly Payments (credit card only)

Please select your payment method: Check: # _____ Credit Card: Visa MC Disc AmEx

Account Number: _____ Exp Date: ____/____

Name as it appears on card: _____ CVN (3 digit #): _____

Billing Address (If different from above): _____

STEP 5 Agreement and Authorization

By signing below I agree to the following:

To adhere to the mission and purpose set forth by the Michigan Chiropractic Pediatric Association.

For Doctors of Chiropractic

1. I hold a Doctor of Chiropractic degree from an accredited chiropractic college.
2. I am licensed and recognized to practice chiropractic in the State of Michigan.
3. I have current malpractice insurance that meets the requirements by the State of Michigan.

Please include with your application the following:

- Copy of your chiropractic license.
- Copy of your malpractice insurance.
- Copy of your pediatric and/or Webster Certification if applicable.

For Affiliate Healthcare Practitioners

1. I hold a degree/certification from an accredited college/organization in my respective discipline.
2. I am licensed/recognized to practice in the State of Michigan.
3. I have a current malpractice insurance policy that meets the requirements set forth by the State of Michigan.

Please include with your application the following:

- Copy of your degrees/licenses/certifications (all that apply).
- Copy of your malpractice insurance.
- Letter of recommendation from a Doctor of Chiropractic.

Print Name: _____

Signature: _____ **Date signed:** _____

For Official Use Only

Membership Accepted Date Accepted: _____ Authorized by: _____ (Initialed) _____

Total Annual Dues \$ _____ Payment Received on: _____

Quarterly Payments Option: \$ _____ starting the _____ quarter (date) _____