International Chiropractic Scoliosis Board - Membership Form 2014

Name_____

Address_____

City_____ State_____ Zip_____

Phone: H_____ W_____ Fax_____

Chiropractic / School_____ States of Current Licensure_____

Clinic website: _____

To better meet your needs, we would appreciate your answers to the following:

How did you learn about the ICSB?_____

Practice Setting

□ Private Practice
□ Outpatient Clinic
□ Faculty / Teaching Clinic
□ Health Maintenance Organization
□ Oriental Medicine
□ Neurology
□ Other_____
□ Nutrition
□ Multi-Disciplinary
□ Group Practice
□ Preventive Medicine / Wellness
□ Manual Medicine

Membership Type (Fiscal Year of July 01 to June 30)

□ DC Member - $250
□ Student Member - $150
□ Associate Member (non-DC physician/PT) - $150
□ Corporate Member - $1000

Email address: _____ (Invoice will be emailed to this address)

By completing and signing this application for membership, the applicant supports and fosters the tenets and purposes of the ICSB and acknowledges that lack of support and fostering of the tenets and purposes of the ICSB will lead to denial or revocation of membership.

Signature:_____ Date:_____