

MISSISSIPPI CHIROPRACTIC ASSOCIATION, INC.

MEMBERSHIP FORM

Vickie M. Webb, Executive Director

P.O. Box 1266 Summit, MS 39666

Telephone (601)276-3336 Fax (601)276-3335

Full Name		Date of Birth / /		MS License#	
Spouse Name				Cell#	- -
Home Address		City		Home#	- -
		State		Zip	-
Email Address					

Clinic Name		Clinic Phone	- -
Clinic Address		Clinic Fax	- -
		City	
		State	
		Zip	-

For Membership Directory Purposes	
Chiropractic College Attended	Date Graduated
Adjusting Technique(s)	

I hereby attest to the accuracy of the forgoing information and apply for membership in the Mississippi Chiropractic Association, Inc. I agree to comply with the bylaws and code of ethics of this Association. I also understand that failure to remit dues will result in the suspension of rights and privileges of membership.

Please mark appropriate section.

I WANT MY DUES TO STAY ON CHECK DRAFT (OR) CREDIT CARD DRAFT

One Time Drawl for full amount or Bill my account monthly .

APPLICANT'S SIGNATURE _____ **Date** _____

Credit Card Number	Exp. Date / /
---------------------------	----------------------

Membership for Calendar Year 2009 (January – December)

Type of Practice		Annual	Monthly Draft	Type of Practice		Annual	Monthly Draft
<i>Active Practice Includes One Convention</i>	<input type="checkbox"/>	\$725	\$60	<i>Active Practice Conventions paid separately</i>	<input type="checkbox"/>	\$450	\$38
<i>First Year In Practice</i>	<input type="checkbox"/>	Complimentary Membership		<i>Honorary (75 years or older) or Special arrangements</i>	<input type="checkbox"/>	Complimentary Membership	
<i>Second Year in Practice</i>	<input type="checkbox"/>	\$150	\$12.50	<i>Third Year in Practice</i>	<input type="checkbox"/>	\$250	\$21
<i>Fourth Year in Practice</i>	<input type="checkbox"/>	\$350	\$29	<i>Fifth Year in Practice</i>	<input type="checkbox"/>	\$450	\$38

Mississippi Chiropractic Association

2009

Authorization Agreement for Automatic Payments

By Credit Card or Bank Draft

Full Name		Phone			
Account Address		City			
Your office or home		State		Zip	-
Bank or Financial Institution Name				Branch	
City		State		Zip	
Checking Acct. #			Transit/ABA#		

Credit Card	<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard				
Card Number			Expiration Date	/ /	
Name as it appears on card					

I hereby authorize the MISSISSIPPI CHIROPRACTIC ASSOCIATION to initiate on or about the 25th of each month, debit entries to my checking account, as provided above or from my voided check or from my credit card information provided above. I hereby authorize the Depository Institution named above to debit the same from my account. Said debits shall be for the amount of the monthly dues as noted on the application and agreement of membership. I understand that the amount will be adjusted by the MISSISSIPPI CHIROPRACTIC ASSOCIATION if I change my membership classification. The MISSISSIPPI CHIROPRACTIC ASSOCIATION, INC. reserves the right to cancel this plan (or my participation therein).

Authorized Signature

Date

Note: Please return one completed copy of this authorization and a VOIDED CHECK (if using bank drafting) on your account.

Return to:

Vickie M. Webb, MCA Executive Director

P.O. Box 1266

Summit, MS 39666

601-276-3336

601-276-3335 fax