



MCA Member Application

___ YES I want to become member of the MCA! The only association for my profession in the state that provides key benefits not found elsewhere.

Clinic Name: _____

Full Name: _____ Birth date ____/____/____

Mailing Address: _____

City: _____ State: _____ Zip: _____

County: _____ Years in Practice: _____

Phone: _____ Fax: _____

Mobile: _____ Email: _____

Clinic Website: _____

MN Legislative District (Clinic) _____ MN Legislative District (Home) _____
(Call MN House Information for your legislative district numbers- (651)-296-2146)

Chiropractic College: _____ Year Graduated: _____

DC Date Licensed: ____/____/____ DC License Number: _____

Top 4 Techniques Practiced: _____

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 thirty days past due.

Signed: _____ Date: _____

Membership Dues Annually:

Variable. Please see dues information below

Please send this form with payment to:

MCA
4620 West 77th Street, Suite 100
Edina, MN 55435

Or Fax to: 952-882-9397

Email: ejohnson@mnchiro.com

Check Payable To: The Minnesota Chiropractic Association or MCA

Credit Card Authorization for Payment

Name on Card: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Credit Card Type: Visa MasterCard American Express Discover

Credit card number: _____ Expiration Date: _____

Credit Card Pin: _____ (3 digit-MC, Visa, Discover- 4 digit- Amex.)

Signature: _____ Date: _____

Associate Business Members \$300.00
(1 fiscal year) Begins any month

Chiropractic Assistants/Chiropractic Tech \$42.25
(Individual 1-fiscal period)

CA/CT- 3 or more in same office \$105.00
(3 registered for 1-fiscal period)

Non-Practicing DC Member \$157.50

Retiree \$80.00

Out of State Member \$50.00

Students FREE

College Faculty Member \$105.00

<u>Practicing Doctors</u>	<u>QTR</u>	<u>YEAR</u>
Same Year Licensed	0.00	\$42.25
1 Year Licensed	\$42.25	\$169.00
2 Years Licensed	\$84.50	\$338.00
3 Years Licensed	\$142.50	\$570.00
4+ Years Licensed	\$195.00	\$780.00
Practice Relief (Part Time Dr)	\$92.50	\$370.00