



# Arkansas Chiropractic Society 2009 Membership Form



## APPLICATION FOR MEMBERSHIP:

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

OFFICE ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

BUSINESS PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_

FAX NUMBER \_\_\_\_\_ e-mail \_\_\_\_\_

GRADUATE OF WHICH COLLEGE? \_\_\_\_\_ Date of graduation \_\_\_\_\_

COLLEGE EDUCATION AND OTHER ACADEMIC DEGREES \_\_\_\_\_

PROFESSIONAL ORGANIZATION MEMBERSHIPS \_\_\_\_\_

ARKANSAS CHIROPRACTIC LICENSE NUMBER \_\_\_\_\_

OTHER STATES HOLDING LICENSE IN \_\_\_\_\_

HOW LONG HAVE YOU BEEN IN PRACTICE ? \_\_\_\_\_

*The dues are complimentary for doctors practicing in Arkansas for the first calendar year.*

### **2009 Membership Form**

\_\_\_\_ I am a renewing member. Enclosed are my annual dues of **\$150.00** for the year of **2009**.

\_\_\_\_ I would like to join ACS. Enclosed are my completed application and my annual dues of **\$150.00** for the year of **2009**.

▶ Check or money order enclosed in the amount of \$ \_\_\_\_\_  
Make checks payable to: ACS & mail to 2108 Fort Street, Barling AR 72923.

▶ For credit cards list # and sign. VISA, MASTER # \_\_\_\_\_  
Signature: \_\_\_\_\_

DEBIT # \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Name \_\_\_\_\_ Signed \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Office Phone \_\_\_\_\_ Your fax# \_\_\_\_\_ Doctors License # \_\_\_\_\_

**ACS Offices are open Mon-Thurs. (12:00 – 5:30) Phone: 1-479-782-4361 or 24 Hour Fax: 1-479-782-4616**