



Chiropractic Fellowship of PA Membership Application

EST. 1967
CHIROPRACTIC
FELLOWSHIP
of Pennsylvania

Name _____

License Number _____

Practice Name _____

Address _____

City, State, Zip _____

Telephone _____ FAX _____

E-mail _____

Years in Practice Student 0-2 years _____ years Retired (No Active License)
Type of Practice Solo Group Associate

Chiropractic Association memberships : ICA ACA WCA IFCCO

Chiropractic College _____ Year Graduated _____

Dues Category	Annual	Quarterly
<i>(Please check only one.)</i>		
<input type="checkbox"/> First two years in practice	\$200	\$50
<input type="checkbox"/> More than two years in practice	\$500	\$125
<input type="checkbox"/> Associate D.C. in practice/Part time (16 hours or less per week)	\$250	\$62.50
<input type="checkbox"/> Student/ Retired DC (Non-active license)/ Out-of-state D.C.	\$25	n/a

Method of Payment

- Check for annual dues enclosed
- Check for quarterly dues enclosed
- Charge annual dues to VISA MasterCard American Express
- Debit dues quarterly from VISA MasterCard American Express

Name on Card _____

Card number _____

Exp Date _____ Security V-Code on Back of Card _____

Authorized signature _____ Date _____

I agree to abide by the bylaws of CFoP and to attend as many meetings and functions as possible.

Signature _____ Date _____

Mail or fax application:
Chiropractic Fellowship of Pennsylvania
908 North Second Street, Harrisburg PA 17102
717-441-6042 ~ 717-236-2046 (fax)

CFOP Membership Application