Join the
Chiropractic Fellowship
Of Pennsylvania
Working to protect your license!

Membership Credit Card Authorization

Fax to 717-236-2046 or scan and email to info@chirofellowpa.org. Questions? 717-441-6042

Name: _____

Company:_____

Billing Address of Credit Card:_____

Billing City, State & Zip: _____

Telephone: _____

Email: _____

Credit Card Information

I authorize CFoP to deduct my credit card as checked below (please check one)

First two years in practice:
_____$50 quarterly for one year _____$200 annually for one year

More than two years in practice:
_____$45 per month for one year ($540)_____ $45 continuously each month past one year
_____$125 quarterly for one year _____$125 continuously each quarter past one year
_____$500 annually for one year _____$500 per year past one year

Associate D.C. in practice/Part time (16 hours or less per week):
_____$62.50 quarterly for one year _____$250 annually for one year

Student/Retired DC (Non-active license/Out-of-state DC):
_____$25 annually

Name on credit card: _____(please print)

Card Number: Type of Card: ___ VISA ___ MasterCard ___Am. Exp. CC Billing Zip Code _____

Expiration Date: _____ V Code: _____ Signature: _____