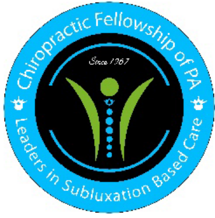

Chiropractic Fellowship of Pennsylvania

Working to Protect Your License!

Membership Credit Card Authorization

Name: ________________________________ Company: _________________________________

Address _______________________________ City ____________________ State __ Zip ______

Telephone: ____________________________ Email: _____________________________________

Payment Information

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

First two years in practice
❒ One payment of $200
❒ Two payments of $100 for two consecutive months

More than two years in practice
❒ One payment of $500
❒ Two payments of $250 for two consecutive months

Associate DC in practice/Part time (16 hours or less per week)
❒ One payment of $250
❒ Two payments of $125 for two consecutive months

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

Credit Card Information

Credit Card Number: ________________________ Expiration Date: _______ CVV Code: _____

Billing Address of Card: ____

City: ____________________________________ State: ______ Zip Code: _______________

Name on Card: _____________________________ Signature: _____________________________

Mail, fax, or email completed form to:
Chiropractic Fellowship of Pennsylvania
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info@chirofellowpa.org ● www.chirofellowpa.org