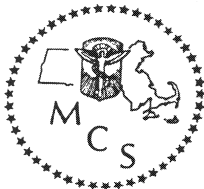


**MASSACHUSETTS CHIROPRACTIC SOCIETY, INC.**  
**OFFICIAL MEMBERSHIP APPLICATION**

SUBMIT APPLICATION TO:  
Massachusetts Chiropractic Society, Inc.  
76 Woodland Street, Methuen, MA 01844  
Email: mcs@masschiro.org  
Fax: 978-975-0468



*Please complete in its entirety.  
Please type or print.*

NAME \_\_\_\_\_  MALE  FEMALE  
(If active, as you wish it to appear on your membership certificate)

DATE OF BIRTH \_\_\_\_\_ MARITAL STATUS: (S,M,W,D) \_\_\_\_\_ SPOUSE'S NAME \_\_\_\_\_

MASS. LICENSE NO. \_\_\_\_\_ DATE LICENSED \_\_\_\_\_ YEARS IN PRACTICE \_\_\_\_\_ IN MASSACHUSETTS \_\_\_\_\_

OFFICE ADDRESS \_\_\_\_\_ OFFICE PHONE (\_\_\_\_) \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ HOME PHONE (\_\_\_\_) \_\_\_\_\_

CELL PHONE (\_\_\_\_) \_\_\_\_\_ FAX (\_\_\_\_) \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_  
(Please print clearly - Your e-mail address will not be published or distributed)

CHIROPRACTIC COLLEGE \_\_\_\_\_ DATE GRADUATED \_\_\_\_\_  
(IF STUDENT, EXPECTED GRADUATION DATE)

HAVE YOU EVER HAD A LICENSE TO PRACTICE REFUSED, REVOKED, OR SUSPENDED ?  YES  NO  
IF YES, PLEASE ATTACH A LETTER EXPLAINING FULLY.

**MEMBERSHIP CLASSES** - Please check appropriate box.

- |  |   |
|--|---|
| <input type="checkbox"/> 8TH (OR MORE ) YEAR OF PRACTICE - \$1,000 | <input type="checkbox"/> 2ND YEAR OF PRACTICE - \$240                 |
| <input type="checkbox"/> 7TH YEAR OF PRACTICE - \$840              | <input type="checkbox"/> 1ST YEAR OF PRACTICE - \$120                 |
| <input type="checkbox"/> 6TH YEAR OF PRACTICE - \$720              | <input type="checkbox"/> MILITARY (full time)- DUES EXEMPT            |
| <input type="checkbox"/> 5TH YEAR OF PRACTICE - \$600              | <input type="checkbox"/> AFFILIATE - (OUT OF STATE) - \$50            |
| <input type="checkbox"/> 4TH YEAR OF PRACTICE - \$480              | <input type="checkbox"/> STUDENT - \$10 (must join before graduation) |
| <input type="checkbox"/> 3RD YEAR OF PRACTICE - \$360              |   |

I, the undersigned, hereby make application for membership in the Massachusetts Chiropractic Society, Inc. I hereby agree to conform to all rules and regulations as printed in the Constitution and By Laws, or other regulations and laws which may be enacted hereafter by the Society, and agree to govern myself strictly to its Code of Ethics. I agree to keep the Secretary informed of any changes of address, to pay my dues and assessments, if any, within thirty days after notice, and to participate in Massachusetts Chiropractic Society and Local Society Activities.

Date \_\_\_\_\_ Signature \_\_\_\_\_

**DUES MUST ACCOMPANY APPLICATION.**

**METHOD OF PAYMENT**

Check Enclosed  Mastercard  Visa

Card No. \_\_\_\_\_ Exp. Date \_\_\_\_\_

Signature \_\_\_\_\_ Amount \$ \_\_\_\_\_

Cardholder's Billing Address and Zip Code  
\_\_\_\_\_

If paying by check, make payable to MCS.  
Questions? Call 1-800-442-6155 or 978-682-8242.

**DO NOT WRITE IN THIS AREA**

Date application received:  
\_\_\_\_\_

Date approved by Board of Directors:  
\_\_\_\_\_

Amount received with application:  
\$ \_\_\_\_\_

Date approved by General Membership  
\_\_\_\_\_