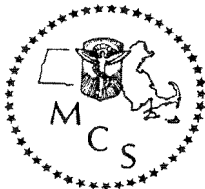


MASSACHUSETTS CHIROPRACTIC SOCIETY, INC.
OFFICIAL MEMBERSHIP APPLICATION

SUBMIT APPLICATION TO:
Massachusetts Chiropractic Society, Inc.
400 Washington St, #102, Braintree, MA 02184
Email: traceymasschirosociety@gmail.com
Fax: (781) 848-9941



*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(Please print clearly - Your e-mail address will not be published or distributed)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 (781) 849-0000.

DO NOT WRITE IN THIS AREA

Date application received:

Date approved by Board of Directors:

Amount received with application:
\$ _____

Date approved by General Membership
