

MASSACHUSETTS CHIROPRACTIC SOCIETY, INC.
OFFICIAL MEMBERSHIP APPLICATION

MAIL OR FAX APPLICATION TO:
 Massachusetts Chiropractic Society, Inc.
 76 Woodland Street, Methuen, MA
 01844



Please complete in its entirety.
 Please type or print.

DATE _____

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 _____ ZIP _____ OFFICE PHONE (____) _____

HOME ADDRESS _____ ZIP _____ HOME PHONE (____) _____

FAX (____) _____ E-MAIL ADDRESS _____ (Your e-mail address will be secure)

COLLEGE _____ LOCATION _____ YEARS COMPLETED _____ DEGREE _____

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CHIROPRACTIC COLLEGE _____ DATE GRADUATED _____
(IF STUDENT, EXPECTED GRADUATION DATE)

CITY AND STATE _____ ZIP _____

ARE YOU IN ACTIVE PRACTICE ? _____ WHERE ? _____ ZIP _____

ARE YOU LICENSED IN OTHER STATES ? _____ LIST STATES: 1. _____ Lic. No. _____ 2. _____ Lic. No. _____

LIST STATES WHERE YOU HAVE PRACTICED: 1. _____ DATE _____ TO _____ 2. _____ DATE _____ TO _____

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

NAME OF LOCAL SOCIETY _____

PERSONAL REFERENCE _____
(ONE OTHER DOCTOR OF CHIROPRACTIC)

MEMBERSHIP CLASSES - Please check appropriate box.

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

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

5/2010