ACA Council on Diagnosis and Internal Disorders

Member Application

Please print clearly. Information will be posted on our website.

Name and Degree(s): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: H(_____) _____ W(_____) _____

FAX(____) _____ E-Mail: _____

Office Website: _____

Chiropractic School_____

State of Current Licensure_____

To better meet your needs, we would appreciate your answers to the following selections:

CURRENT BOARD CERTIFICATIONS (check all that apply)

- □ Radiology
- □ Chiropractic Internist
- □ Orthopedics
- □ Occupational Health
- □ Sports Medicine
- □ Radiology
- □ Neurology
- □ Nutrition
- □ Behavioral Health
- □ Physiological Therapeutics
- □ Other

PRACTICE-EMPLOYMENT TYPE (check all that apply)

- □ Private Practice
- □ Oriental Medicine
- □ Outpatient Clinic
- □ Acupuncture
- □ Faculty/ Teaching
- □ Clinic Multi-Disciplinary
- □ Occupational/Rehabilitative
- □ Group Practice
- □ Preventive Medicine/Wellness
- □ Other _____

MEMBERSHIP TYPE (check one)

- □ CFP (New Member First Year $150 USD)
- □ Renewal - $120 (USD)
- □ Student Member- $40 (USD)
- □ Corporate Member - $500 (USD)
- □ Collect Member - $500 (USD)
- □ Associate Member (non-DC) $90 (USD)

- □ Please accept my additional contribution of $ _____ to further the work of the Council

By completing and signing this application for membership, the applicant supports and fosters the tenets and purposes of CDID. Lack of support and fostering of the tenets and purposes of CDID will lead to denial or revocation of membership.

Signature _____ Date _____

Pay by

- □ VISA
- □ MC
- □ Check

If credit card, Card # _____
Exp Date _____
3 digit security code_____

If credit card, you can fax application to 920-682-6983 or mail it to the address below.
If you're paying by check, mail the application & check (payable to: "CDID") to:

CDID-ACA
Attn: Loretta Brandl
3713 Calumet Avenue
Manitowoc, WI 54220