INVEST IN YOUR FUTURE: JOIN PCA NOW!

For less than $1.75 a day, you will **NEVER** face reimbursement, legislative, and administrative challenges **ALONE**.

MEMBERSHIP APPLICATION

Please Circle One: Dr. Mr. Ms. Full Name: ______________________________

Practice Name: ______________________________

(If registering as a Group Member, the GROUP practice name is required)

Primary Practice Address: ______________________________

City: ______________ State: ________ Zip: ____________ County: ______________

Phone: (____)______________ Fax: (____)______________ Email:______________

For GROUP Member or Spouse Member, indicate the primary member's full name: ______________________________

Were you a previous PCA Member? ❑NO ❑Yes **Referred By:** ______________________________

(Must be completed at the time of submission. NO EXCEPTIONS!)

Chiropractic College: ______________________________ Graduation Date: ______________

PA License #: ______________________________ Date PA License issued: ______________ _

*By signing, I agree to abide by charter provisions and bylaws of the Pennsylvania Chiropractic Association during my membership. *Signature ______________________________

MEMBERSHIP TYPE ❑**Annual** ❑**Quarterly** (If annual or quarterly is not checked you will be charged for the full an

Please check the box that applies:

TYPE	ANNUAL	QUARTERLY
❑1 Year License	$72	—
❑2 Year License	$150	—
❑3 Year License †	$300	$75
❑4 & 4+ Year License †	**$600***	**$150**
❑Group Primary†	$600	$150
❑Group Member	$200	—

TYPE	ANNUAL	QUARTERLY
❑Student	$15	—
❑Retired	$30	—
❑Semi-Retired †	$300	$75
(Semi-retired works less than 15 hrs./wk.)		
❑Non-Resident	$60	—

†Dues are prorated after February 1st. Call for exact rates.

*** Please fill out the Recurring Payment Authorization Form (separate form) if you would like to have your payments automatically charged to your Credit Card.**

If you have any questions please call PCA home office 717-232-5762

PAYMENT INFORMATION

❑My check is enclosed in the amount of $__________ Check #__________

❑Please bill my credit card: ❑Visa ❑MasterCard ❑Discover

❑Credit Card# ______________________________ Exp. Date____/____ Validation Code: __________

Name on Card: ______________________________

Card Zip Code, if different from above: ____________

Signature: ______________________________

Make check payable and mail to:
Pennsylvania Chiropractic Association
1335 North Front Street
Harrisburg, PA 17102

If paying by credit card, you may fax application to: **717-232-8368.**
*If faxing application, please call 717-232-5762 or email pca@pennchiro.org to confirm receipt.

10/2016 W