American Black Chiropractic Association

3915 Cascade Road, Suite 220, Atlanta, GA 30331
Phone: (404) 647-2225
www.ABCAchiro.com

APPLICATION FOR MEMBERSHIP

☐ NEW MEMBER ☐ RENEWAL

DATE OF APPLICATION _____

I, the undersigned, hereby make application for membership, and if accepted, I agree to abide by the Constitution and By-Laws of the American Black Chiropractic Association; perform all requested duties and support the association to the best of my abilities. I understand the membership fee shall cover the period from June 25th of the current year through the conclusion of the national convention (on or about June 26th) of the following year; and that all membership dues payments made during that time shall cover the annual registration fees for the upcoming national convention.

Name _____

Address _____

City _____ **State** _____ **Zip Code** _____

Telephone No. _____ **Fax** _____

Email Address _____

***Students Only*: School** _____ **Tri/Semester** _____

Authorized Signature _____

Committees of interest: ☐ Membership ☐ Scholarship ☐ Communications ☐ Convention Planning

Please select one of the membership options below:

DOCTOR (DC)

- ☐ **EARLY**: **BY FEBRUARY 28, 2016** -- **$275**
- ☐ **REGULAR**: **MARCH 1- MAY 31, 2016** -- **$300**
- ☐ **LATE/WALK-UP**: **JUNE 1 – JUNE 25, 2016** -- **$350**

LIFETIME (DC)

- ☐ **EARLY**: **BY FEBRUARY 28, 2016** -- **$1400**
- ☐ **REGULAR**: **MARCH 1- MAY 31, 2016** -- **$1425**
- ☐ **LATE/WALK-UP**: **JUNE 1 – JUNE 25, 2016** -- **$1475**

☐ **1ST YEAR SABCA GRADUATE (FREE)**
Please submit copy of transcript or diploma for date verification.

☐ **STUDENT (SABCA MEMBER 1 TIME FEE) $50**

☐ **SABCA CHAPTER (ANNUAL DUES) $50**
Please submit SABCA Chapter Report to Regional Director along with annual dues.

All payments are due in full at the time of application, and will be processed upon receipt of both application and payment.
TOTAL FEE: _____

METHOD OF PAYMENT

☐ **CASH** ☐ **CHECK** ☐ **DEBIT/CREDIT CARD NUMBER** _____

Card Exp. Date _____ **CVV#** _____ **Name on card** _____

Billing Address (if different than above) _____

If paying by check, please make payment out to the American Black Chiropractic Association and mail to:
ABCA Treasurer, PO Box 725013, Atlanta, GA 31139

For questions, contact our Membership Chairman, Dr. Danielle Brown at drdaniellebrown@gmail.com or call (803)387-3218*

ABCA OFFICE USE ONLY Date Paid: _____ Check No: _____ Amount: $ _____ Initials: _____