



American Black Chiropractic Association

P.O. Box 725013, Atlanta, GA 31139

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 29th) 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, 2019** -- \$275
- REGULAR: **MARCH 1- MAY 31, 2019** -- \$300
- LATE/WALK-UP: **JUNE 1 – JUNE 28, 2019** -- \$350

LIFETIME (DC)

- EARLY: **BY FEBRUARY 28, 2019** -- \$1400
- REGULAR: **MARCH 1- MAY 31, 2019** -- \$1425
- LATE/WALK-UP: **JUNE 1 – JUNE 28, 2019** -- \$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. Norquitta Haynes at dr.norquitta@gmail.com****

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