

MEMBERSHIP APPLICATION AND RENEWAL

2008

Fiscal year Oct 07-Sept 08



The undersigned hereby makes application to be elected a member of the International College of Integrative Medicine (ICIM), a nonprofit corporation organized for the purpose of promoting the exchange of technical data and related information of clinical application and evaluating contemporary medical practices and patient care.

If elected to membership, all rights and obligations are governed by the documents of incorporation and rules and regulations of the College. It is understood and acknowledged that application to be elected a member creates no contract between the undersigned and the International College of Integrative Medicine, and imposes no obligation upon the college to elect the undersigned to membership.

Requirements for active membership include annual submission of this Membership Application along with payment of annual dues. In addition, if checked please include the following documents:
 curriculum vitae, photocopy of state license.

Applicant name, printed

Signature

Date

Please print clearly.

Applicant Name		Degree(s)	
Name of Practice (if applicable)		Website	
Street Address	City	State	Zip
Office Phone	Office Fax	E-mail	
Membership Type	<input type="checkbox"/> MD or DO \$ 350 <input type="checkbox"/> international MD or DO 300 <input type="checkbox"/> new member <input type="checkbox"/> Associate ¹ 300 <input type="checkbox"/> renewing member <input type="checkbox"/> Staff (Affiliate) ² 100 <input type="checkbox"/> Student, Intern, Resident 75 <input type="checkbox"/> Retired 50	1. Associate - recognized doctorate degree in a clinical or basic science field, e.g. PhD, ScD, Dr.PH, DDS, DMD, DPM, DC, ND, OD 2. Affiliate - may be conferred upon any person formally involved in health care, e.g. PA, NP, RN, PT, MA, CMA	
Please list medical specialties			
Payment Information			
<input type="checkbox"/> check # _____ (payable to ICIM) or <input type="checkbox"/> credit card (please complete below)			
Credit Card: <input type="checkbox"/> Visa <input type="checkbox"/> MC <input type="checkbox"/> Am. Exp.		Expiration	security code (on back)
#			
Billing Address	City	State	Zip
Name on Card	Authorizing Signature	Date	

Please send this completed application, along with the applicant's supporting documents and payment, to:
 ICIM, P.O. Box 271, Bluffton, Ohio, 45817

phone (866) 464-5226, fax (610) 680-3847, e-mail: wendy@icimed.com

For your protection, ICIM does not encourage faxing or e-mailing credit card information.

All MD/DO and Associate members are listed on our website for patient referrals. You may add a photo, quote, and/or bio to your listing at no cost. Please send these electronically to wendy@icimed.com.