

MEMBERSHIP APPLICATION & RENEWAL FORM

2012



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. ICIM's membership committee will review all supporting documents and, if approved, members will be awarded a certificate of membership. **ICIM Membership includes a one year membership in the Alliance for Natural Health. To opt out, please contact us.**

Requirements for active membership include payment of annual dues. All new member applications must include the following documents: Curriculum Vitae, photocopy, fax, or scan of a valid state license Membership Community Review.

All ICIM members are expected to attend 1-2 ICIM meetings per year.

Printed Name		Degree(s)	
Name of Practice (if applicable)		Website	
Street Address	City	State	Zip
Office Phone	Office Fax	E-mail you would like to use for ICIM updates	Cell Phone (office use only)
Facebook Profile or Page Name	Twitter <input type="checkbox"/> yes <input type="checkbox"/> no	Linked In <input type="checkbox"/> yes <input type="checkbox"/> no	Blog
Membership Type	<input type="checkbox"/> MD or DO	\$365	<i>1. Associate - recognized graduate degree in a clinical or basic science field, e.g. PhD, ScD, Dr.PH, DDS, DMD, DPM, DC, ND, OD, Nurse Practitioner</i> <i>2. Affiliate - may be conferred upon any person formally involved in health care, e.g. PA, RN, PT, MA, CMA</i>
<input type="checkbox"/> new member	<input type="checkbox"/> Associate ¹	\$315	
<input type="checkbox"/> renewing member	<input type="checkbox"/> Affiliate ²	\$115	
	<input type="checkbox"/> Student, Resident	\$55	
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"/> Disc. <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 (419)358-0273, fax (610) 680-3847
 or email wendy@icimed.com

All MD/DO members are listed on our website www.icimed.com for patient referrals. To complete your online profile, let us know your medical specialties. You may add a photo, quote, and/or bio to your listing at no cost. Please send these electronically.