AMERICAN ACUPUNCTURE COUNCIL

Application *for* Membership

Contact and Practice Information:

Full Name (First, Middle, Last) | Practice / Clinic Name

Office Address (include Suite #) | City | State | Zip

Mailing Address – If Different from Office Address | City | State | Zip

Office Phone | Alternate Phone (Home, Cell, etc.) | Fax | Email

Acupuncture License Number(s) | State Issued | Date Issued | Acupuncture College and Location | Year Graduated

Social Security Number | Birth Date | Gender: ❒ Male ❒ Female

Fax or Mail Completed App & Payment to:

SCHLITT INSURANCE SERVICES
1717 Indian River Blvd., Ste 300
Vero Beach, FL 32960
772-567-1188
772-778-1416 - FAX

Payment Detail (See Coverage Options page for choices):

Installment Due: .....

Optional Additional Insured (5%) .....

Total Payment Remitted _____

Credit Card Payments, Complete Following:

Card Type: ❒ Visa ❒ MasterCard ❒ American Express

Card #: _____

Expires: _____

You are hereby authorized to charge my credit card for the amount indicated for liability coverage through the American Acupuncture Council. I agree to pay this amount according to the terms of the card issuer agreement.

Signature: _____