

Membership Application



Please Print All Information — Incomplete Application Forms Cannot Be Processed

Ms. Mr. Mrs. Dr. _____ Male Female

Mailing Address: _____

City: _____ State: _____ Zip: _____ Email address: _____

Home phone #: _____ Business phone #: _____ Fax #: _____

Date of Birth: ____/____/____ Manual Therapies Specialty: _____

Education: _____

Medical License (State and Number—if applicable): _____

Professional Affiliations: _____

Please enclose substantiating documents with your application, i.e., state license, certificates

Membership Options

Professional Membership—\$300

Associate Membership—\$225
(Student)

Application Fee—\$50
(Professional Membership Only)

Method of Payment

Do not send cash. **Make checks payable to AMMA and mail to: 1845 Lakeshore Dr., Suite 7, Muskegon, MI 49441**

Check/Money Order

Visa/Mastercard

Discover

American Express

Card Number (please print clearly)

Expiration date (month & year)

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\$

Cardholder's Signature

Amount

I, the undersigned applicant, do hereby state that all information contained in this application is true to the best of my knowledge and I have read the Code of Ethics. I understand that any false statements made in this application or subsequent renewals of this application shall void my membership.

Signature (REQUIRED)

Date