



Date: _____

COMPANY INFORMATION

Name: _____

Product/Service Description: _____

Office Address _____

City _____ State _____ Zip _____

Office Phone: _____ Office Email (if applicable): _____

Employee Contact #1

Name: _____ Cell: _____

Email: _____

Employee Contact #2

Name: _____ Cell: _____

Email: _____

AFFILIATE MEMBERSHIP FEES

- ◇ \$45 Processing Fee
- ◇ \$1,000 Annual Dues
(must be paid in full at beginning of membership)

PAYMENT OPTIONS

Please designate how you will pay by checking the box next to it. Note – membership must be paid for ***in full*** at the start of the membership agreement.

- Credit Card (Designate Below)
- Check - Check Number: _____

MEMBERSHIP AGREEMENT

I understand that I am entering into a one-year Affiliate membership agreement with the Texas Chiropractic Association. This agreement cannot be broken prior to one year and not without 30 days' written notice. By signing below, I agree to abide by the Texas Chiropractic Association bylaws, strive to attend TCA events and conferences, and promptly inform the association of any changes in the above information.

Signature: _____

Date: _____

AUTHORIZATION AGREEMENT

I (We) authorize the Texas Chiropractic Association, hereinafter called Company, to initiate this debit entry to my credit card.

AUTHORIZED SIGNATURE: _____

Print Name on Credit Card: _____

Credit Card Number: _____ Expires (MM/YY): _____