American Academy of Hospital Chiropractors
Membership Application

Name: _____ Date of Birth: _____

Address:_____

City: _____ State: _____ Zip: _____

Phone: _____ Fax:_____ Email:_____

Graduate of: _____ Date: _____

Other degrees held and where obtained:_____

References (Name and phone--two DCs and two MDs)

_____

_____

Lic. No: _____ State: _____ Lic. No: _____ State: _____

Lic. No: _____ State: _____ Lic. No: _____ State:_____

Membership in other chiropractic organizations:_____

_____

Hospital affiliations and category of privileges* : _____

_____

Approved Hospital Protocols Course Certificate Date: _____

I agree to abide by the Constitution, By-laws and Code of Ethics of the AAHC.

I want my contact information posted on the AAHC web site _____ (initial here)

Signature: _____ Date: _____

*Privilege Categories: 1: Co-admit, ER & OR; 2: Co-admit with ER or OR; 3: Co-admit only; 4: Hospital Clinic with no co-admit; 5: Clinic associated with hospital, but not located on hospital campus

First year membership fee is $75.00, second year and on is $100.00.
Enclose check or money order payable to *American Academy of Hospital Chiropractors* and mail to: AAHC, c/o Joseph Salamone, D.C., 22 Carlos Drive Fairfield, NJ 07004