



# Council on Chiropractic Orthopedics

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## MEMBERSHIP APPLICATION FORM

Name: \_\_\_\_\_  
Practice Name: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
E-mail: \_\_\_\_\_

**Are You a Member of the Following?: (All Colleges Members Must be ACA Members)**

ACA member: \_\_\_\_\_ Yes / No  
(Must be a member of the ACA to apply for membership in all following organizations)

College of Military Chiropractic Physicians Yes / No

**Dues**

\*Certified or General Membership - \$100 \_\_\_\_\_  
\*Faculty/Associate Member (Includes CMCP)- \$50 \_\_\_\_\_  
\*Retired CCO Member – 10 years + - \$25 \_\_\_\_\_  
\*Retired CCO Member – less than 10 years - \$35 \_\_\_\_\_  
\*Supporting Member - \$100 \_\_\_\_\_  
\*Student Member - \$10.00 \_\_\_\_\_  
**TOTAL DUE:** \_\_\_\_\_

**Payment Options:**

c Check# \_\_\_\_\_ enclosed (payable to: CCO)  
c Credit Card# \_\_\_\_\_ Visa/MasterCard –Expiration \_\_\_\_\_  
**(\*note: credit card payments reflect charges to the ACA)**

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*I hereby certify this information factual and I agree to abide by the Code of Ethics and Bylaws of the Council on Chiropractic Orthopedics.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

*In order to update our records please provide the following information, as applicable:*

\_\_\_\_\_  
CCO certificate #      DABCO certificate #      Academy FACO #      ACCO certificate #  
\_\_\_\_\_  
DACO certificate # \_\_\_\_\_