International College of Integrative Medicine

MEMBERSHIP APPLICATION

2009

Jan 09-Dec 09

The undersigned hereby makes application to be elected a member of the International College of Integrative Medicine (ICIM), a nonprofit corporation organized for the purpose of promoting the exchange of technical data and related information of clinical application and evaluating contemporary medical practices and patient care.

If elected to membership, all rights and obligations are governed by the documents of incorporation and rules and regulations of the College. It is understood and acknowledged that application to be elected a member creates no contract between the undersigned and the International College of Integrative Medicine, and imposes no obligation upon the college to elect the undersigned to membership. ICIM's membership committee will review all supporting documents and, if approved, members will be awarded a certificate of membership.

Requirements for active membership include payment of annual dues. All new member applications must include the following documents: ☐curriculum vitae, ☐photocopy of a valid state license ☐ membership community review.

All ICIM members are expected to attend 1-2 ICIM CME meetings per year.

_____ _____ _____

Applicant name, printed | Signature | Date

Please print clearly.

Applicant Name			Degree(s)
Name of Practice (if applicable)			Website
Street Address	City	State	Zip
Office Phone	Office Fax	E-mail	Home Phone (office use only)

Membership Type

☐ new member

☐ renewing member

☐ MD or DO	$ 350
☐ International MD or DO	$350
☐ Associate[1]	$300
☐ Staff (Affiliate)[2]	$100
☐ Student, Resident	$50
☐ Retired	$50

1. *Associate - recognized doctorate degree in a clinical or basic science field, e.g. PhD, ScD, Dr.PH, DDS, DMD, DPM, DC, ND, OD*
2. *Affiliate - may be conferred upon any person formally involved in health care, e.g. PA, NP, RN, PT, MA, CMA*

Payment Information

☐ check #_____ (payable to ICIM) ***or*** ☐ credit card (please complete below)

Credit Card: ☐ Visa ☐ MC ☐ Disc. ☐ Am. Exp. #		Expiration	security code (on back)
Billing Address	City	State	Zip
Name on Card	Authorizing Signature		Date

Please send this completed application, along with the applicant's supporting documents and payment, to:
ICIM, P.O. Box 271, Bluffton, Ohio, 45817, phone (419)358-0273, fax (610) 680-3847, e-mail: wendy@icimed.com

For your protection, ICIM does not encourage faxing or e-mailing credit card information.

All MD/DO and Associate members are listed on our website www.icimed.com for patient referrals. Please let us know your medical specialties. You may add a photo, quote, and/or bio to your listing at no cost. Please send these electronically to wendy@icimed.com.