MEMBERSHIP APPLICATION

Complete Only One Section Below

Individual Membership

Individual Full Name_____ ☐ MD ☐ DO ☐ PA ☐ NP ☐ RN ☐ ____

Nickname _____

Job Title _____

Organization Name _____

Address _____

_____

City _____ State _____ Zip _____

Country _____

Phone _____ Fax _____

Email Address _____

(required to access members-only)

Individual Membership Dues - $150
(skip to Payment section below)

Corporate Membership

Organization Name _____

Main Organization Address _____

_____

City_____ State_____ Zip _____

Country _____

Main Phone_____ Fax_____

Organization Website _____

Number of Locations: ☐ 1-2 Clinics ($225)
☐ 3-4 Clinics ($300)
☐ More than 5 Clinics ($375)

Please complete the appropriate section below to name individuals who will receive this membership's benefits.

Corporate Membership Benefits Recipients

If you have chosen a Corporate Membership above, please provide names of individuals who will receive benefits through the membership. *All mailings will go to main organization address.*

❑ **1-2 Clinics (up to 5 people)** ❑ **3-4 Clinics (up to 7 people)** ❑ **5+ Clinics (up to 10 people)**

1. Name _____ Email: _____
2. Name _____ Email: _____
3. Name _____ Email: _____
4. Name _____ Email: _____
5. Name _____ Email: _____
6. Name _____ Email: _____
7. Name _____ Email: _____
8. Name _____ Email: _____
9. Name _____ Email: _____
10. Name _____ Email: _____

☐ Check here if you would like to provide alternate addresses for some individuals.

Payment

☐ Credit Card (Visa or Mastercard only) ☐ Check enclosed

CC# _____ Exp. _____

Name on card _____

Fax to 813-315-2529 or Mail to UCAOA Attn: Membership, P.O. Box 777, Valrico, FL 33595-0777
(call 813-239-6429 to confirm fax receipt)

Rev 3-3/08