

ANC Practice Member Application

please print

Last Name: _____ First Name: _____

Address: _____ City/State/Zip: _____

Tel: _____ Fax _____ E-mail _____

Country if other than USA: _____ Date of Birth ____ / ____ / ____

Name of ANC referring doctor (if applicable) _____

Please accept my membership in the Association for Network Care.

Individual membership annual fee \$36

Family membership annual fee \$60

Family membership includes significant other and children (at same address) Please print the names of family members and their date(s) of birth _____

If you wish to express a higher level of financial support, you may choose to join as a

sustaining member \$125 (individual) \$200 (family)

visionary member \$250 (individual) \$400 (family)

Your membership in the ANC adds your voice to the growing family of people who view individual and planetary healing to be in relationship to one another, and respect the value of a healthy, adaptable nervous system in the pursuit of greater health and well being.

The ANC is pioneering the advancement of compassionate and scientific models which better represent health, wellness and the relationship of the spine and nervous system to healing and an improved quality of life.

The Association publishes newsletters, develops and supports research, helps develop fellowship within its community, conducts an annual convention with exciting speakers for the lay person and the professional, and is developing a Web site which will be a link to the latest advancements in healing and Network Care.

Special programs and professional discounts may be offered by various practitioners and other organizations for members of the Association for Network Care.

Thank you for your membership application. Your membership dues and donations help the services and values you enjoy in health and wellness care to remain available to you and those you love.

Your membership will be automatically renewed unless other written instructions are received.

Signature: _____

Date: _____

My check is enclosed for \$ _____

Please charge \$ _____ to my credit card Mastercard Visa

____ / ____ / ____ exp. ____ / ____

A.N.C.
 444 N. Main Street
 Longmont, CO 80501
 (tel) 303-678-8101
 (fax) 303-678-8089
www.associationfornetworkcare.com