ACUPUNCTURISTS *of* HAWAII

A Non-Profit Professional Association

Membership Application Form

1. CONTACT INFORMATION

Full Legal Name: _____
Last Middle First

Hawaii License No.: ACU- _____ Exp. Date: _____ Other Professional Licenses (if any): _____

Street Address: _____City:_____ State: ____ Zip Code:_____

Phone: (____) _____ Fax: (____) _____ Email: _____

2. BUSINESS INFORMATION (if applicable)

Business Name/DBA: _____

Phone: (____) _____ Fax: (____) _____ Website: _____

Mailing Address (**ONLY** if different from above): _____

3. EDUCATION

Name of Institution: _____ Month/Year Graduated: _____
Other Education: _____
Other Certifications or Qualifications: _____

4. FOR STUDENTS ONLY

Name of Institution: _____ Expected Graduation: _____
MM/YY

5. PROFESSIONAL ETHICS AND DISCLOSURE Please answer the following questions:

Have you ever been convicted of a crime in any jurisdiction that has not been annulled or expunged? [ ] Yes [ ] No
Have you ever been a defendant in a criminal or civil litigation connected with a health care practice? [ ] Yes [ ] No
Has any license ever been suspended, revoked or otherwise subject to disciplinary action? [ ] Yes [ ] No
Are there any disciplinary actions pending against you? [ ] Yes [ ] No

6. MEMBERSHIP FEES/PAYMENT Please check one Member Category only:

[ ] Regular Member
(Licensed Acupuncturist) $100

https://square.link/u/GMvGK3px

[ ] Associate/Student Member
(Students and Supporters) $50

https://square.link/u/LZB4bLWu

[ ] Checks Payable to: ***Acupuncturists of Hawaii*** mail to: 100 N. Beretania Street, #203, Honolulu, HI 96817

[ ] Visa [ ] MC [ ] AMEX Card # _____ CVV: _____ EXP: ___/___ Zip _____

7. DECLARATION

I hereby apply for membership and declare that all the information submitted with this application are true, complete, and correct to the best of my knowledge, I also understand that misstatements or omissions of material facts may be the cause for denial of this application or for suspension or revocation of membership.

Print Name: _____ Signature: _____ Date: _____

FOR OFFICE USE ONLY		□ Fees Paid
□ Hawaii Licensed Acupuncturist	□ Approved	Amount $_____ Check #_____ Visa / MC / AMEX
□ Associate/Student	□ Denied	Processed By: _____ Date: _____

Tel: 808-888-0323 Fax: 808-521-2271 Email: director@acuhawaii.org Website: acupuncture808.org