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

Please check one Member Category only: **[ ] Regular (LAc) $100** **[ ] Associate $50** **[ ] Student $25**

Annual Fees (*Subject to Change*)

7. PAYMENT

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

[ ] Visa [ ] MC [ ] AMEX Card # ______________________________ CVV: ______ EXP: ___/___ Zip _______

8. 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/Area of Expertise: ______	□ Pending	Processed By: ______________________ Date: _________
□ AOM Student	□ Denied	Comments: ______________________________