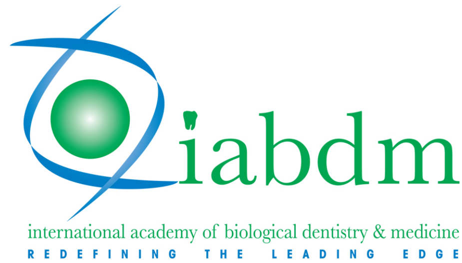

Application for Membership

Date_____________

Name____

Address____

____

City_____________________________State_______________Zip_________Country______

Phone _____________________________ Fax______________________Cell _________________

e-mail ____

Degrees ____

Please Circle which membership

Yearly Dues Doctor (DDS, DMD, ND, DC, DO, MD, PhD)

Standard member $495 in full, or $45 a month (address/ phone listed on website, referrals to your office, reduced fees to conferences, ability to attend mini meetings, certificate of membership)

Sponsoring member (Must be certified) $1000 in full, or $90 a month (standard membership benefits and direct link to your website, photo on homepage under Sponsoring member and again with your listing)

Affiliate/Non Dr. $75.00 (Certificate of affiliate membership, reduced fees to conferences, ability to attend mini meetings, certificate of membership)

Student $75.00 (Certificate of student membership, reduced fees to conferences, ability to attend mini meetings)

Payment Circle one: MC Visa AMEX Check (Make payable to IABDM)

Credit Card # ____Exp Date ______ Security Code _____

Signature____

Would you like a mentor? _________________

Remit to
IABDM
c/o Dawn Ewing Executive Director
19122 Camellia Bend Circle
Spring, Texas 77379
281-651-1745 phone/fax
www.IABDM.org

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