



Enrollment Form

Primary Applicant (Please print clearly.)

Name _____ Male Female

Address _____

City _____ State _____ Zip _____

Home Phone (____) _____ Birthdate _____

Acclaim may also be used by relatives living in your household. Please list below.

1. Name _____

Relation _____ Birthdate ____/____/____

2. Name _____

Relation _____ Birthdate ____/____/____

3. Name _____

Relation _____ Birthdate ____/____/____

4. Name _____

Relation _____ Birthdate ____/____/____

Payment Information

Annual \$30 Membership Fee

\$30 check or money order enclosed and payable to OSCIPA

Please bill my credit card \$30 VISA Discover MasterCard American Express

Name on Card _____

Credit Card Number _____ Expiration Date _____

I understand I will be notified for annual renewals of Acclaim 30 days before my expiration date.

Signature _____ Original Application Date _____

Chiropractor's Office

Acclaim Personal Chiropractic Physician (APCP) _____

APCP Phone Number (____) _____

Date Mailed to OSCIPA _____

Mail To:

OSCIPA, 5350 E. 46th Street, Suite 122, Tulsa, OK 74135-6601

