

## Undergraduate Membership

Student Membership is open to full-time students enrolled in a postgraduate program that, upon graduation, will be granted a degree enabling the student to obtain a license to diagnose under his/her state law.

Visit [www.icakusa.com](http://www.icakusa.com), for more information!

The ICAK-U.S.A.'s primary goal is to provide leadership in applied kinesiology through individualized professional development and to advance education in health care. Undergraduate Membership offers professional identity and an opportunity for personal development.

Membership in the ICAK-U.S.A. provides students with the tools to utilize a range of therapies which focus on prevention, nutrition, and wellness. In addition, Undergraduate Members gain access to networking opportunities with established Professional Applied Kinesiologists around the country.

### ANNUAL MEMBERSHIP BENEFITS:

- Quarterly Educational CD Membership Mailer
- Quarterly E-Newsletter
- Access to the Online Student Forum
- Discounts on ICAK-U.S.A. Products
- Discounted Registration Fees for ICAK-U.S.A. Meetings

**Annual Dues: \$25**



### ICAK-U.S.A. CENTRAL OFFICE

6405 Metcalf Ave., Suite 503  
Shawnee Mission, KS 66202

Phone: 913-384-5336

Fax: 913-384-5112

E-mail: [icak@dcj-kansascity.com](mailto:icak@dcj-kansascity.com)

# ICAK-U.S.A. UNDERGRADUATE MEMBERSHIP

## Application

Student Membership is open to full-time students enrolled in a postgraduate program that ,upon graduation, will be granted a degree enabling the student to obtain a license to diagnose under his/her state law.

### Applicant Information:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City/State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Country

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Email Address (REQUIRED)

\_\_\_\_\_  
Professional College(s)

\_\_\_\_\_  
Anticipated Graduation Date

### Membership Requirements & Fees:

Please include the Annual Dues of \$25 with your application.

I hereby agree to abide by the Bylaws of the International College of Applied Kinesiology – U.S.A.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Payment:** Payment Method (Please Circle)    Cash    Check    Visa    MasterCard    AMEX

Amount Enclosed: \_\_\_\_\_

\_\_\_\_\_  
Card Number

\_\_\_\_\_  
Expiration Date

\_\_\_\_\_  
Name as it appears on the card

\_\_\_\_\_  
Signature

Please send your completed application and membership requirements to:

**The ICAK-U.S.A. Central Office**

6405 Metcalf Ave., Suite 503

Shawnee Mission, KS 66202

Phone: 913-384-5336

Fax: 913-384-5112

Email: [icak@dc-kansascity.com](mailto:icak@dc-kansascity.com)

