

# MEMBERSHIP APPLICATION

Date \_\_\_\_\_

Name \_\_\_\_\_

Mailing Address \_\_\_\_\_  
\_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_ Zip \_\_\_\_\_

Country \_\_\_\_\_

Business Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Home Phone \_\_\_\_\_

Business Phone \_\_\_\_\_

Email \_\_\_\_\_

Website \_\_\_\_\_

Areas of specialization: (describe your practice)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe Training \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What types of animals do you assist?  
\_\_\_\_\_  
\_\_\_\_\_

How many clients do you see each month? \_\_\_\_\_

Who refers clients to you? \_\_\_\_\_  
\_\_\_\_\_

How do you advertise? \_\_\_\_\_  
\_\_\_\_\_

How did you learn of IAAMB? \_\_\_\_\_  
\_\_\_\_\_

Are you willing to chair or participate in a committee?  
 Yes  No If yes, what are your interests?  
\_\_\_\_\_

Do you want to be on the Internet referral list?  
 Yes  No

If yes, please view the IAAMB website under "Members"  
and list what you would like to have posted.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If purchasing PROFESSIONAL LIABILITY INSURANCE  
complete the following information:

Birth date \_\_\_\_\_ Years in Practice \_\_\_\_\_

Employment:  Full time  Part-time

Self-employed:  Yes  No

If yes, incorporated type:  Corporation  LLC  
 Sole Proprietor  Partnership

Do you currently own a Professional Liability Policy?  
 Yes  No If yes, expiration date: \_\_\_\_\_

Which company is the policy with? \_\_\_\_\_

Do you have a claim pending?  Yes  No

Additional Insured Option: (\$10.00 per each addition)

Business name \_\_\_\_\_

Owner's name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_

Prof. Relationship \_\_\_\_\_

Annual IAAMB Membership Fee USD	= \$ 94.50
Annual Insurance Plan (\$2 million)	= \$160.00
To purchase both	= \$254.50
Additional Insured	=
Amount enclosed	_____

Method of payment:

Check Enclosed  Money Order Enclosed

Visa / MasterCard  Discover

**Credit Card #**  
\_\_\_\_\_

Expires \_\_\_\_/\_\_\_\_ 3 Digit Security Code \_\_\_\_\_

Refer your friends.

Whom of your colleagues in animal care would like  
us to contact to join the IAAMB?

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_

Email \_\_\_\_\_