

**THE INTERNATIONAL AND AMERICAN ASSOCIATIONS
OF CLINICAL NUTRITIONISTS**

APPLICATION FOR MEMBERSHIP

Type in form. Save to computer. Then email/fax/mail to office.

**Please attach additional sheets if added space is needed.*

Date: _____

Name: _____ Degree(s) _____

Office Address: _____

City: _____ State: _____ Zip: _____ How long at present work address? _____

If less than 3 years, please give previous address: _____

Residence Address: _____

City: _____ State: _____ Zip: _____ How long at present home address? _____

Preferred mailing address Home Office Email: _____

Telephone: Office: () _____ Home: () _____ Fax: () _____

Sex: Male Female Birthdate: ____/____/____ Social Security #: _____

Education (Schools, Universities-Addresses and Telephone Numbers)- You may use extra paper to explain.

_____ Dates: _____ Degree: _____

_____ Dates: _____ Degree: _____

_____ Dates: _____ Degree: _____

Are you in practice? _____ Full Time/Part time? _____ Practice Type: _____ How long? _____

Intern/Residency/Special Training: _____

What Percentage of your practice is nutritional? (estimate) _____% Are you licensed? _____

Yr. of license: _____ State: _____

License #: _____ License Specialty/Field _____

Are you certified? _____ As? _____ State: _____ Cert. #: _____

Have you ever been convicted of a felony? Yes No In which state? _____ Year of charge: _____

Disposition: _____ If YES, please explain: _____

Have you ever been charged for practicing without a license? Yes No If YES, please explain: _____

Have you had disciplinary action brought against you by your Professional Board? Yes No

If YES, please explain: _____

Have you ever had a malpractice suit brought against you? Yes No

If YES, please explain: _____

How long have you been employed in a health-related industry? _____

Please give name, address, telephone number of your employer: _____

Please provide us with 2 (two) affirmations as to your personal and professional character and integrity.
These references must be from the natural foods industry or health care field: one may be from your employer, a fellow competitor or the head of a supplement company with whom you do business. The other must be a health professional, i.e., a chiropractor, clinical nutritionist, M.D., naturopath, etc.

1. Print Name: _____ Title: _____

Address: _____

City: _____ State: ____ Zip: _____

Firm or Company: _____

Signature: _____

2. Print Name: _____ Title: _____

Address: _____

City: _____ State: ____ Zip: _____

Firm or Company: _____

Signature: _____

TO THE IAACN NATIONAL BOARD OF DIRECTORS:

I certify to being of good moral character and that the above information is true and correct, of which I authorize verification. If above information is false, I understand there will be no refund of application fee. I agree to abide by IAACN's Code of Professional Ethics and Responsibility.

Signature _____ Date: _____

**INTERNATIONAL AND AMERICAN ASSOCIATIONS
OF CLINICAL NUTRITIONISTS (IAACN)**

MEMBERSHIP CATEGORIES AND ANNUAL DUES:

PROFESSIONAL MEMBER \$395

Limited to Certified Clinical Nutritionists (CCN's).

Entitles to all benefits, rights and privileges accorded to Professional Members.

PROFESSIONAL ASSOCIATE MEMBER \$360

Limited to eligible licensed doctors who have no CCN certification.

ASSOCIATE MEMBER \$300

Limited to practicing professionals who currently utilize nutrition counseling as a primary practice focus or adjunct to other practice.

STUDENT MEMBER \$45

Open to full-time students enrolled in a college or university pursuing a degree in science and/or nutrition.

CORPORATE MEMBER \$900

Open to any business, organization, or corporation involved in nutrition, nutritionally related products or services, or motivation to further the course of clinical nutrition.

Payment Method: Check (payable to IAACN)

Visa/ MasterCard/ AMX/ Discover

Card Number: _____ Exp. Date: _____

CVC Code: _____

Name on card: _____

Email: _____

PLEASE SEND COMPLETED APPLICATION, DUES, AND RESUME TO:

**The International and American Associations
of Clinical Nutritionists**

400 Chisholm Place, Suite 303

Plano, Texas 75075

Office (972) 407-9089 Fax (972) 250-0233

Email: khenry@clinicalnutrition.com