



TOTAL:
Date/Time:

OFFICE USE ONLY

At the Door Registration Form

Select Registration Type:

Check here	Registration Type	Price
<input type="checkbox"/>	ICPA Member – Chiropractor	\$425
<input type="checkbox"/>	ICPA Member – DC Associate	\$325
<input type="checkbox"/>	ICPA Wellness Advocate/ General Attendee	\$225
<input type="checkbox"/>	ICPA Student Member	\$175
<input type="checkbox"/>	HPA Member	\$325
<input type="checkbox"/>	Chiropractor – Non-Member	\$655
<input type="checkbox"/>	Wellness Advocate/ General Attendee	\$375
<input type="checkbox"/>	Student – Non-Member	\$350

Contact Information:

First Name _____ Last Name _____

Email Address _____ Phone Number _____

Will you be requesting CE credits? NO YES (\$45 per state)

State 1:	License #1:	State 3:	License #3:
State 2:	License #2:	State 4:	License #4:

Payment Method:

CARD (on site) **CASH** **CHECK** -- Check # _____

I agree to the following:

- I am aware that my photograph may be taken during the course of the Summit weekend. By registering for The Freedom for Family Wellness Summit I am agreeing that the ICPA, Inc. can use my photograph or video images for its own marketing purposes in print publication, internet or any other media.
 - I agree that my information (name and email) can be shared with presenters and sponsors of the Summit.
- OPT-OUT of having information shared with presenters and sponsors of the Summit.

Signature _____ Date _____