



APPLICATION TO RENEW MEMBERSHIP

PLEASE PRINT LEGIBLY	APPLICANT INFORMATION	PLEASE PRINT LEGIBLY
Name of Member:		Date:
Current address:		
City:	State/Province:	Postal Code:
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Email:	
Web Address:		Daytime Phone:
Evening Phone:	Fax:	Cell Phone:
Highest Degree Obtained:		
OCCUPATION INFORMATION		
LIST YOUR PRIMARY PROFESSION:		
(Check one) I am: <input type="checkbox"/> Licensed <input type="checkbox"/> Certified <input type="checkbox"/> Both Licensed and Certified <input type="checkbox"/> Neither Licensed nor Certified		
Please list all current healthcare and spiritual healing licenses and certifications:		
Please list the healing techniques and modalities you currently use:		
Please check the Membership Classification requested: <input type="checkbox"/> Professional Member: \$235.00 USD or CAD <input type="checkbox"/> Insurance Member: Per Quotation <input type="checkbox"/> Journal Member: \$150.00 USD or CAD <input type="checkbox"/> Internet Member: \$75.00 USD or CAD		Person to be certified as Medical Biofeedback Supervisor: _____ Name of person(s) to be certified as Biofeedback Technicians: _____ _____

Fax to: 888-642-9992, mail attachment to: info@mbacb.com or mail to: MBACB, 361 So Camino Del Rio #102 Durango, CO 81303-7997 - Enclose check or money order. Check here if you paid online by credit card.