



Membership Application

Name _____ Date _____

Company _____ Title _____

Professional Degree in Healthcare field? ____ Yes ____ No Please indicate: _____

Address _____

City _____ State/Province _____

Zip/Postal Code _____ Country _____

Telephone _____ Fax _____

E-mail _____

IIPA Instructor _____

Membership Categories:

- **Supporting Member** - \$59.00. *A Supporting Members will be entitled to receive the Newsletter and discounts on webinars and Symposiums. All Supporting Members will receive a letter of gratitude for their support of IIPA and Iridology education. Eligibility: See general requirements below.*
- **Student Member** - \$59.00. *A verification of enrollment of Iridology Level I & II is required. All Student Members will receive a letter of gratitude for their support and to encourage their Iridology education success. Eligibility: See general requirements below.*
- **Certified Comprehensive® Iridology Member** - \$125.00. *A CCI Member will be awarded a Certified Comprehensive® Iridologist Certificate upon completion of all IIPA Iridology educational requirements. This certificate will have an Effective date and an Expiration date and will be issued every two (2) years. The Expiration date will be for a 2-year period when the Certified Iridologist successfully completes the IIPA CEU Program requirement. Membership dues will need to be paid annually. Eligibility: IIPA Certified Iridologist*
- **Lifetime Member** - \$3,000.00. *Lifetime members will join and receive a certificate stating Lifetime Member with no Expiration date. Lifetime Members will not be required to fulfill the IIPA CEU Program and as a Lifetime member the one-time fee will not need to be renewed.*

General Requirements: *Individuals and organizations in all classes of membership shall have a reputation for sound character and integrity; agree to abide by the Bylaws, the Member Code of Professional Ethics and such other rules or regulations as may be adopted by the Board of Directors.*

Select method of payment:

Enclosed is my check in the amount of \$_____.

Please charge my credit card (Visa / Mastercard) in the amount of \$_____.

Card No. _____ Expiration Date: _____ 3- digit Code _____
(on back of card)

Signature as on card: _____
(Note: All payments are to be made in U.S. funds and are tax deductible if applicable.)