



IIPA

International Iridology Practitioners Association

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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 _____

How did you hear about IIPA? _____

Membership Categories:

- Associate Membership - \$49.00. Eligibility: See general requirements below
- Certified Membership - \$99.00. Eligibility: IIPA Certified Iridologist

***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.)