

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

**APPLICATION FOR MEMBERSHIP**

(Please Print Clearly)

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

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Degree(s) \_\_\_\_\_

Office Name: \_\_\_\_\_

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 #: \_\_\_\_\_

Are you active in community or civic groups? If YES, please explain: \_\_\_\_\_

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:  
Membership Runs January 1 - December 31**

- 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

Card Number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Name on Card: \_\_\_\_\_

Email: \_\_\_\_\_

**PLEASE SEND COMPLETED APPLICATION, DUES, AND RESUME TO:**

**The International and American Associations  
of Clinical Nutritionists  
15280 Addison Road, Suite 130  
Addison, Texas 75001  
Office (972) 407-9089 Fax (972) 250-0233**