



Membership Application

Name _____ Title/Degree _____

Business/Practice Name _____

Address _____

City _____ State _____ Zip _____

Email _____ Website _____

Work# _____ Cell _____ Fax _____

Note: the information above will be used for your referral listing on the website. If you have other sites you want to list or any different information, please include it in your fax. We will not include your cell unless you specify

Professional Affiliations _____

1 year Membership \$100.00 Three ways to pay:

1. Credit Card Payment, MasterCard and Visa only:

Name on card _____

Billing Address _____ Zip _____

Card number _____ Expiration date ____ ____

3 digit security # ____ ____ ____ **Fax this form and any attachments to 863-619-7525**

2. ACH transfer:

IAMT - Institute for the Advancement of Medical Thermology

Wachovia Bank

4405 South Florida Ave

Lakeland, FL 33813

A/C# 2000031817024

Routing # 067006432

Email: info@iamtonline.org **Fax this form and any attachments to 863-619-7525**

3. Submit this form and any attachments with your check payable to:

IAMT

315 Doris Drive

Lakeland, FL 33813

1-800-709-9565

I agree to uphold and abide by the IAMT Guidelines, Code of Ethics and Policy Statements. All of the information above is factual.

Signature _____ Date _____