International Association of Hygienic Physicians (IAHP)

APPLICATION FOR MEMBERSHIP FOR PHYSICIANS,
PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS

Name

Address (Office) Phone #

Address (Home) Phone #

E-Mail

Website

Type of Practice: (Office, Institute, or Other):

EDUCATION

Medical/Chiropractic/Osteopathic/Naturopathic School Attended:

Years of Attendance

Post Graduate Training (and years)

Specialty Certification

State Boards

I learned of the Association from:

STATEMENT OF PERSONAL HEALTH PHILOSOPHY:

Completion of the back page is required.

WHY I WISH TO BE A MEMBER OF THIS ASSOCIATION:

DUES PAYMENT: I have paid the annual dues of $50.00 using the payment link on the IAHP Website.

CERTIFICATION

1. I certify that I was fully educated and trained at a bona fide professional school in one of the following primary care disciplines: Medicine, Chiropractic, Osteopathy, or Naturopathy.

2. I am legally qualified to practice in my state or country.

3. I recognize the therapeutic value of medically supervised water fasting and support the Association's mission to promote its advancement and acceptance.

DATE:_____ SIGNED: _____

RETURN THIS COMPLETED APPLICATION TO:
Please rename and save the completed file using the name format APPLICATION FOR MEMBERSHIP - YOUR FIRST AND LAST NAME

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