COLLABORATIVE PRACTICE
INSTITUTE of MICHIGAN

Resolving Disputes Respectfully

Membership Renewal Form

Name: ____

Credentials/Profession: ____

Address: ____

____

E-mail: ____

Phone: __________________________ Fax: ______________________________

Website: ____

I have attached to this document the following required items:

___ Payment of $140.00 for my annual dues

___ IACP Membership Application

___ Copy of my proof of current profession liability/malpractice insurance coverage

Mail or fax required information to*:*

COLLABORATIVE PRACTICE INSTITUTE OF MICHIGAN
121 W. Washington St., Ste. 300
Ann Arbor, MI 48104
Fax: 734.994.1557
Phone: 734.994.3000

Payment Method:

Check (make payable to CPIM)

Credit Card: ___VISA ____MasterCard ___Discover

Card No.: ______________________________

Exp. Date: _____________ Zip Code:_____________

Name on Account: ___________________________

Amount Charged: $_________________

Signature: ____________________________________