



IIPA

International Iridology Practitioners Association

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Dear IIPA Member:

Please take this opportunity to renew your IIPA Membership, dues are listed below. **Please fill out all information provided and return this form with your payment.**

I am renewing my membership as: (check one)

- 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.

Name _____ Date _____

Company _____ Title _____

Professional Degree in Healthcare field? ___ Yes ___ No Please indicate: _____

Address _____

City _____ State/Province _____

Zip/Postal Code _____ Country _____

Telephone _____ Fax _____

Email _____

In your Iridology practice do you use a: _____ film camera _____ digital camera

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.