WNDA Wisconsin Naturopathic Doctors Association

ASSOCIATE MEMBER APPLICATION

Personal Information

Name:_____

Home Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell:_____

How did you hear of the WNDA? _____

What is your personal area of interest in and/or association with Naturopathic Medicine? (mark all that apply)

_____ patient
_____ family member
_____ collaborative practitioner
_____ collaborative product provider
_____ other: _____

Allied Healthcare Professional Information:

Profession:_____
Business Name: _____
Address: _____
_____
Website: _____
Phone number: _____
Wisconsin License number: _____
Please submit a copy of your Wisconsin license for our records.

Would you like to be informed on the progress of the WNDA? YES/NO
If yes, what is the best way to contact you?

____Email

____ Mail

The annual dues for an Associate member are $75.00.

Please enclose a check payable to the WNDA with your completed application to:

WNDA
P.O. Box 14434
Madison, WI 53708