

JOIN ICAA and become part of a network of professionals committed to improving the quality of life for older adults.

Name _____ Title _____
(Required)
Organization/Agency _____
Mailing Address _____
City _____ State/Province _____
Country _____ Zip/Postal Code _____
Phone (_____) _____ Cell (_____) _____
Email _____

MEMBERSHIP OPTIONS

MEMBERSHIP DUES*

Organization member, 1-4 locations (\$799 each location) _____
(includes 5 staff per location)
Organization member, 5-13 locations (\$535 each location) _____
(includes 5 staff per location, at least 5 locations must be enrolled)
ICAA 100, 14+ locations** (\$6,499, flat fee) _____
(includes 5 staff per location)
Individual (\$259) _____
TOTAL \$ _____

* Fees subject to change. ** Some restrictions apply. Call for information.

PAYMENT INFORMATION

All prices in US Dollars.

Check (payable to ICAA Services Inc.)

Please charge my VISA or MasterCard



_____/_____/_____/_____

Card number _____

Expiration date _____

CVV _____

X _____

Date _____

I acknowledge by signing this membership application that I am requesting ICAA to charge my credit card or cash my check for the amount shown on this form.

MEMBER REFERRAL

Did a colleague refer you to ICAA?
Please write name and email address.

MEMBER PROFILE

How did you hear about ICAA?

Which of the following best describes your affiliation? (Check one)

- Active adult community
 Assisted living
 Independent living
 Skilled nursing
 CCRC
 Area Agency on Aging
 Hospital, rehab, wellness center
 YMCA/YWCA/JCC
 Municipality
 College/university
 Health club
 Corporate fitness center
 Personal training studio
 Association
 Other (Please specify) _____

No. of locations? _____

Will you be expanding, renovating or moving into your community/center in the next 6 months?

Yes No