I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby apply for membership in the Ahava Health Community, a private membership association (hereinafter referred to as the “Association”). With my signature I accept the offer made to become a member of the Association, and I express my agreement with the following declaration and memorandum of understanding.

DECLARATION

This association of members hereby declare that our primary purpose is to protect and maintain our right as US citizens to freedom of choice in matters of our health care. This includes the therapies and modalities we use and when, where and why we use them, and who provides them.

1. As members, we affirm our belief that the Constitution of the United States guarantees all Americans, particularly members of private organizations, the right of freedom of association, speech, assembly, belief and associated activities. These are our inalienable rights.
2. We claim our freedom to choose and accept for ourselves the types of health care modalities that we think are best for determining the cause and correction of our health challenges. We do this in order that we might achieve optimal health and well-being. We reserve the right to include traditional, non-traditional and also unconventional health care and therapy options, plus other healing modalities or techniques used by health care professionals anywhere in the world, which our members choose to deliver – with our approval.
3. We declare and assert our right to select whomever we believe will provide us the wisest counsel and advice in these areas, regardless of their training or licensure status.
4. This association recognizes all persons as members, without respect to race or religion, who are in accordance with our principles and policies.

We assert these rights under the United States national and state constitutions, national and state laws, and the regulations interpreting them.

MEMORANDUM OF UNDERSTANDING

1. I understand that members of the Association that provide services or advice do so in the capacity of fellow members in a private manner and not in the capacity as public healthcare providers. Thus, within the Association, no Public Doctor-Patient or Public Therapist-Client relationship exists.
2. With respect to my activities in and with the Association, I freely choose to change my legal status from that of a public healthcare recipient, to that of a private membership association member. I realize that in doing so, I relinquish certain Federal and State protection and priveleges.
3. I understand that I am joining this private membership group under the common law and the First Amendment of the US Constitution – the right to associate freely.
4. I understand that members seek to help each other achieve and sustain better health. More specifically, our mission is to enable members to improve their health on all levels; physical, mental, emotional and spiritual, through individualized care and advice.
5. I accept that the advice, services and benefits I receive as a member of this Association are not necessarily conventional or traditional.
6. I understand that it is my personal responsibility to evaluate the services, advice and counsel I am offered and educate myself as to their efficacy, risks or desirability in my particular case. I agree that the actions I take, in this regard, are of my own free-will. Thus, I agree to hold harmless the Association and its members from any unintentional liability that might result from the advice or services I receive, except for the harm that could remotely result from an instance of “a clear and present danger of substantive evil” – as determined by the Association and as defined by the United States Supreme Court.
7. Thus, I agree not to file malpractice, civil or criminal lawsuits against a fellow member, unless that member exposes me to a clear and present danger of substantive evil.
8. I agree that Association members are exempt from the provisions of any state Medical Practices Act, Federal Food Safety Modernization Acts, Codex Alimentarius or any similar federal or state legislation designed to “protect the public.”
9. I understand that, since the Association is protected by the First, Ninth and Fourteenth Amendments to the United States Constitution, it is exempt from any action of Federal and State agencies entrusted to "protect the public” – as it relates to any complaints or grievances against the Association. All complaints or grievances will be settled by non-judicial mediation or binding arbitration within the Association.
10. Private member records kept by the Association are strictly private and can only be released upon written request of the subject member. The only exception is if records are subpoenaed by a warrant duly signed and specific as to date and content.
11. I realize that no health screening, resulting conclusions, or health care services are foolproof. For example, if I choose to forego drugs, surgery or symptom treatments that have been recommended by others, in the public sector, I accept that risk. I assert my right of informed consent.
12. I enter into this agreement of my own free will, or on behalf of a designated dependent, without any pressure or promise of benefit.
13. I affirm that I do not represent any state or federal agency whose purpose is to regulate the practice of medicine or any other health care system.
14. I have read and understand this contract and any questions I had were answered fully to my satisfaction.
15. This document consists of my entire agreement for membership and it supersedes any previous agreement I may have made.
16. I understand that $35 of my initial consultation fee is for consideration of my membership.
17. The term of membership begins with the date of the acceptance of this agreement and continues until the dissolution of this Association or until termination of membership by the Association.

IN WITNESS WHEROF, I set my hand on this day to this agreement and completing the registration form above is evidence of my agreement.

Print Applicant’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Accepted by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_