



Membership Application

Please answer all questions and include requested attachments (if applicable). Send your application to ICMAD, 1220 W. Northwest Highway, Palatine, IL 60067, or by fax 847-991-8161. Questions? Email info@icmad.org or call 847-991-4499.

1. Company _____
2. Full Mailing Address _____
3. Business Location Same Additional Locations _____
4. Telephone Number _____ Fax Number _____ Email _____
5. Business Type: Individual Partnership Corporation Joint Venture
6. How Long in Business Under Present Name? _____ At this Location? _____
7. *If your firm has been in business less than three years, attach a resume/biography of principal(s) experience in the cosmetic industry.*
8. Categorize your company: Private Label Manufacturer Contract Manufacturer Brand Name Manufacturer
 Sales Rep Cosmetic Distributor Cosmetic Importer/Exporter Trade Journal R&D/Testing Supplier of Components Formulator Retail Establishment Consultant Other: please describe _____
9. List Full Name and Title of Your Company's Officers: _____

10. List Your Principal Products(If branded, please specify). _____

11. Number of Employees _____
12. Your annual dues are based on your annual sales. Please check the appropriate box. **Note: To have your application considered, dues must be enclosed.** Annual Sales = Annual Dues:
 Over \$10 million sales = \$1,850 dues \$1 Million to \$4,999,999 sales = \$1,200 dues
 \$5 Million to \$9,999,999 sales = \$1,500 dues \$500,000 to \$999,999 sales = \$750 dues
 Less than \$500,000 sales = \$ 450 dues (same for start up companies)
13. How are your products being sold? Salons Wholesale Private Label Distributors Beauty Supply Stores TV Sales Mail Order Mass Market Drug/Chain Stores Department Stores Other, please describe: _____
14. Are you interested in exporting your products? Yes No If yes, where? _____
15. How did you hear about ICMAD? _____
16. Which ICMAD member referred you? _____
17. I have read the Code of Ethics and agree to abide by them? Yes Signature of Applicant _____

I have enclosed a check for _____

Please bill my credit card: Visa Mastercard American Express

Card No. _____ Exp. Date _____ Security Code _____

Signature _____

Name on Card (Please Print): _____

Is this a business card? Yes No Please provide billing address (address, city, state and ZIP)

All applications for membership must be approved by a majority of the ICMAD Board of Directors. Each company is entitled to one vote at the ICMAD annual meeting.

Proxy ballots are issued 30 days prior to the meeting. ICMAD membership may be terminated at any time at the sole discretion of the Board of Directors if the Board concludes that the member has violated the Code of Ethics or the By-Laws of the association.