

Office Use Only:
Chapter: _____
Mailings: _____
Credit Card Approval _____

The Virginia Society for Clinical Social Work, Inc.
2011-2012 Membership Renewal Form
Membership Year July 1, 2011 – June 30, 2012
<http://www.vscsw.org> or vscsw1976@verizon.net

(Please use this form if you are renewing your membership. If you have allowed your membership to lapse for more than 1 year, please fill out the form for New Members)

MEMBERSHIP CATEGORIES AND DUES

Fill out the information for the membership category for which you are eligible:

- FULL** \$ 150
- ASSOCIATE** \$ 115
MSW without Virginia license.
- NEW PROFESSIONAL** \$ 50
A new MSW, applying within six months after graduation for a one-year period following graduation.
- STUDENT** \$ 40
A current full-time student in a Masters or Doctoral Clinical Social Work Program.
Anticipated degree _____ Expected date of graduation _____
School Name _____ Student I.D. Number _____
- AFFILIATE** \$ 65
Retired from practice – Date of retirement _____ or
Out-of-state resident residing in which state _____

I would be interested in active participation with the following Society activities:		
<input type="checkbox"/> Conference	<input type="checkbox"/> Education	<input type="checkbox"/> Fundraising
<input type="checkbox"/> Legislative	<input type="checkbox"/> Membership	<input type="checkbox"/> Mentoring
<input type="checkbox"/> Newsletter	<input type="checkbox"/> Public Relations	<input type="checkbox"/> Serve on local or state VSCSW boards

Membership Renewals are due no later than June 15, 2011.
(Renewals remitted after September 1 will not be included in the VSCSW Membership Directory)

- Donation to the VSCSW Lobbyist Fund** (specify amount) \$ _____

Affirmation: By submitting this application, I affirm that the above information is a true account of my training and experience, and I agree to be bound by the CSWA Code of Ethics.

Signature: _____ Date: _____ Total Enclosed: \$ _____

Print Name: _____

Please mail your registration form and payment to:

VSCSW (Membership)
10106-C Palace Way
Henrico, VA 23238 (see other side)

Directory Information

Please fill out ALL information as we need to check to make sure what is on file is current.
We are updating files and need ALL current information filled in.
Please do not write "Same Info As Last Year" in the space, please fill it in.

Please Print

<p>Home Address</p> <p>Name _____</p> <p>Street _____</p> <p>City _____ State _____</p> <p>Zip _____ + _____</p> <p>Phone _____ - _____ - _____</p>	<p>MSW LCSW Ph.D. BCD (circle all applicable) Other _____</p> <p>Preference for mailings: _____ Home _____ Work</p> <p>E-Mail Address: _____ (Membership votes and notices sent by email)</p> <p>Please indicate which chapter you belong to: _____ Blue Ridge _____ Eastern Virginia _____ Richmond _____ Roanoke</p>
<p>First Work Address</p> <p>Name _____</p> <p>Street _____</p> <p>City _____ State _____</p> <p>Zip _____ + _____</p> <p>Phone _____ - _____ - _____</p> <p>FAX _____ - _____ - _____</p>	<p>Second Work Address</p> <p>Name _____</p> <p>Street _____</p> <p>City _____ State _____</p> <p>Zip _____ + _____</p> <p>Phone _____ - _____ - _____</p> <p>FAX _____ - _____ - _____</p>

CLINICAL PRACTICE INFORMATION – OPTIONAL (This information will be listed in the directory. check all that apply)

Practice Populations	Specific Areas of Expertise								
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%;"><input type="checkbox"/> Children</td> <td style="width: 50%;"><input type="checkbox"/> Individuals</td> </tr> <tr> <td><input type="checkbox"/> Adolescents</td> <td><input type="checkbox"/> Couples</td> </tr> <tr> <td><input type="checkbox"/> Adults</td> <td><input type="checkbox"/> Families</td> </tr> <tr> <td><input type="checkbox"/> Geriatrics</td> <td><input type="checkbox"/> Groups</td> </tr> </table>	<input type="checkbox"/> Children	<input type="checkbox"/> Individuals	<input type="checkbox"/> Adolescents	<input type="checkbox"/> Couples	<input type="checkbox"/> Adults	<input type="checkbox"/> Families	<input type="checkbox"/> Geriatrics	<input type="checkbox"/> Groups	<div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="border-bottom: 1px solid black; width: 100%;"></div>
<input type="checkbox"/> Children	<input type="checkbox"/> Individuals								
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<input type="checkbox"/> Adults	<input type="checkbox"/> Families								
<input type="checkbox"/> Geriatrics	<input type="checkbox"/> Groups								

Payment Information:

Please make all checks payable to VSCSW: check # _____

Credit Cards: VSCSW accepts Master Card and Visa.

Name on Card _____ Expiration Date _____

Card Number _____ 3 Digit Code on Back _____

Signature (must be signed) _____