

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

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

(Please use this form if you have never been a member of VSCSW **OR** you have allowed your membership to lapse for more than 1 year)

MEMBERSHIP CATEGORIES AND DUES

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

- FULL** An individual who is a Licensed Clinical Social Worker currently licensed in good standing by the Commonwealth of Virginia. **PLEASE ENCLOSE A PHOTOCOPY OF YOUR LICENSE.**
 Highest graduate degree Year _____ School _____
 Other state(s) in which you are licensed _____ \$ 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 _____
- 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: _____

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) _____

ENCLOSED IS MY DUES PAYMENT: (Full members must enclose a copy of license)

- _____ \$150 Full
- _____ \$115 Associate
- _____ \$ 50 New Professional
- _____ \$ 40 Student
- _____ \$ 65 Affiliate

DIRECTORY INFORMATION

Please fill out all information.

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

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

Practice Populations	Specific Areas of Expertise
<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	_____ _____ _____

GENERAL INFORMATION

PROFESSIONAL EXPERIENCE

List or attach clinical social work and related experience:

Dates	Name of Business/Organization	Job Description

REFERENCE: How did you hear about the VSCSW?

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 |