



**A Chapter of the American Mental Health Counselor Association
(AMHCA)**

MEMBERSHIP APPLICATION / OR RENEWAL

Please complete and mail to the appropriate address below.

Name (Last) _____ (First) _____ Date Submitted _____

Home

Address: _____ (City) _____ (State) _____ (Zip) _____

Name of Employment Site _____ Position _____

Work

Address _____ (City) _____ (State) _____ (Zip) _____

Phone:

(Preferred) _____ (Other) _____

E-mail Address: _____ Work County: _____

Certifications: _____

Licenses: _____

Work Setting (CHECK ALL THAT APPLY):

Private Practice, School, Hospital, Community Behavioral Health, Residential Treatment Facility, Nonprofit Agency, For Profit Agency, Other? _____

Membership Options

<input type="checkbox"/> AMHCA/WVLPCA Unified Dues \$195.00 Wachovia Bank Box 758717 * Make Check Payable to AMHCA * 21275 You may also join online at www.amhca.org	Mail to: AMHCA c/o P O Baltimore, MD
<input type="checkbox"/> Clinical Membership (LPC's only) \$75.00 <input type="checkbox"/> Associate Membership \$40.00	
<input type="checkbox"/> Student Membership \$5.00 (Must have school/professor information completed to be able to utilize this option) College or University _____ Professor Signature _____ Prof Phone _____ # _____ Date _____	

Payment Options:

CHECK: Make Payable to **WVLPCA**

CREDIT CARD: Please Circle: VISA ~ DISCOVER ~ MASTERCARD

Exp. Date: _____ Total Amount: \$ _____ Your Signature: _____

Mail to: WVLPCA
 PO Box 1405
 Charleston, WV 25325