CAPP MEMBERSHIP APPLICATION

Name: ____ Date: ______________________
(If hyphenated or double last name, circle the name you wish used for alphabetical listing.)

Application for _____ Full Member $100.00 annual dues – open to licensed professionals only
_____ Associate Member $65.00 annual dues
_____ Student Member $25.00 annual Dues School: ___________________________

Business Address: ____

____

Phone No. ____________________ Fax No. ____________________ E-mail _______________________

Last Degree: Degree ________ Year ________ University ___________________________________

Major Field ____

Member APA: ___ Yes ____ No ____ In process Member Div. 39. ___ Yes ____ No ___ In process

License, Certification or Registration:

Registration # ___________________________ State _____________________ None __________

Independent Practice: ______ Yes ______ Full Time ______ Part Time ______ No

MAJOR PRESENT EMPLOYMENT:

Type of Work: ____

Place: ____

OTHER AFFILIATIONS:

Hospital or Clinic: ____

University: ____

Other: ____

Signature ______________________________________

I prefer mail be sent to _____ my business address _____ my home address
For CAPP directory purposes, you may publish information on my ____ business ____ home ____ both

Please return application and check to: Chicago Association for Psychoanalytic Psychology
645 N. Michigan Ave., Ste. 800, Chicago, Il. 60611