Chico Regional Chapter
California Association of Marriage and Family Therapists
www.chicocamft.com
P.O. Box 2070 Chico, CA 95927

2011-2012
Membership Application Form

Requirements for membership include:

1. Current CAMFT membership (Associate and Agency Members Exempt)
2. Current MFT License in good standing
3. Registered Intern or Trainee status with BBS
4. Student ID and documentation of major or program

New this year - Agency Membership - Provides the following benefits:

a. Agency listed on the website
b. Agency licensed employees can be Chico Chapter Members for ½ price ($20) – must be State CAMFT members.
c. Agency pre-licensed employees can be Chico Chapter Members for free if they are State CAMFT members; if they do not belong to State CAMFT they can still enjoy membership rates for meetings etc.

Membership Category:
☐ Clinical $40.00 ☐ Associate: $40.00 ☐ Agency: $100
☐ Licensed Agency Member Employee $20 ☐ Pre-licensed Agency Member Employee $0
☐ Pre-licensed Registered Interns: $20.00 ☐ Pre-licensed Students: $10.00

☐ **New** ☐ **Renewal**

Attention: Most of our communication with members is via email. If you want to receive notifications by regular mail please initial here. _____

Name: _____ _____
Last First

Mailing Address: _____
Street Address

_____ _____ _____
City State Zip Code

Phone: _____ **Email:** _____

Website:_____ **License or Registration Number:**_____

State CAMFT Member? Yes ____ No_____ **CAMFT Membership Number:**_____

Agency Employed by: _____

Membership dues are based on the academic calendar year. Please make check payable to Chico CAMFT.

Signature: _____ **Date:**_____

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Information for publication on our website and referral directory:

Information will be published exactly as you state it here. DO NOT fill in any information you do not want visible to the public.

Name: _____ _____ _____ _____
Last First Degree License

Office Address: _____
Street Address

_____ _____ _____
City State Zip Code

Phone: _____ **Email:** _____

Website:_____ **License or Registration Number:**_____

Populations Treated: ☐ Adolescents ☐ Adults ☐ Children ☐ Couples ☐ Families ☐ Groups

Accept Insurance: Yes____ No_____ **Specialties/Modalities (limit 5)**:

Include a short blurb about your practice/work/agency: (you may also email this to: chicocamft@gmail.com) (for examples look online at www.chicocamft.com)

You may send a picture to: chicocamft@gmail.com

I approve all of the above information for publication in any media form.

_____ _____
Signature Date