



MEMBERSHIP APPLICATION

Please type or print plainly: Dr. ____ Mr. ____ Ms ____

NAME _____

OFFICE ADDRESS

Fax _____

Phone _____ Office _____ Home _____

HOME ADDRESS

Preferred Mailing Address: Home ____ or Office ____

Preferred Phone: Home ____ or Office ____

E-MAIL _____

I am applying for: () Diplomat () Associate Status () Emeritus

SOCIAL WORK EDUCATION

Graduate School _____ Degree(s) _____

Graduated: Year & Month

Other

Clinical Social Work License_____

Jurisdiction_____

POST-MASTER'S PROFESSIONAL EXPERIENCE (Include past ten years of practice):

Name of Agency, Address of Agency, Supervisor and number of hours worked. If additional space is needed, please add a separate sheet or back of this sheet.

Publications: Name of book or articles.

Other:

Are you a member of another profession? _____ Specify_____

I want to become a member of ICAPP because

List professional organization affiliations: How long?

How long have you been in the practice of Clinical Social Work? _____

Are you currently in the private practice? Yes _____ No _____

Number of hours _____

If yes, for how long? _____

Are you currently in agency practice? Yes _____ No _____

Number of hours _____

If yes, for how long? _____

If not currently in private practice do you plan to be in the future? Yes _____ No _____

Are you interested in a Mentoring relationship with an ICAPP Member? Yes _____
No _____

What are your specialties (choose four to be listed in the Directory)? Individual _____
Couple _____ Family _____ Group _____ Child _____ Adolescent _____ Adult _____ Depression _____
Anxiety _____ Sexual Abuse _____ PTSD _____ Custody/Divorce _____ Eating Disorders _____
EMDR _____ Gay/Lesbian _____ Geriatrics _____ Substance Abuse _____

Do you utilize professional consultation? _____ How?

Explain _____

What is the name of your ICAPP-CSW sponsor?

ICAPP is a working organization in which each member is expected to actively participate. Please indicate ways in which you wish to contribute, or check below:

Public Relations _____

Committee _____

Fund Raising _____

Fiscal Planning _____

Newsletter _____

Membership Committee _____

Annual Conference _____

Book Reviews for Newsletter _____

Committee _____

Conference Moderator's Committee _____

Special Projects _____

I affirm the above (including attached material) to be true and correct statements.

Signature of Applicant and Date

Please remit the membership fee (U.S. funds) with this application, making a check payable to ICAPP

Diplomate (more than 3 years experience as a clinical social worker) **\$150.00**

Associate (less than 3 years experience as a clinical social worker) **\$ 60.00**

Please mail check and completed application to membership chair:

James Donnelly DSW, LCSW, Diplomate
160 E. 89th St #1B
New York NY 10128

Phone: 212-879-7086
[Email: porik@nyc.rr.com](mailto:porik@nyc.rr.com)

Applicants can expect normal processing of application to take four to six weeks.