

New York State Society for Clinical Social Work, Inc.

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MEMBERSHIP APPLICATION

NAME	D:	D.O.B.:				
E-mail	Address:					
Home .	Address:		Zip	: Pl	none:	
Private	e Address:		Zip	: Pl	none:	
Agency	y/Institute/University:					
Addre	ss:		Zip	:P	Phone:	
Please	check Preferred Mailing Address:	□ Agency	□ Private Practice	□ Home		
	Academic Training: (Start with	Graduation Social	Work School)			
	School	Address	Major	Degree	Year	
3.						
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I.	Post Master's Experience: Agen				1 1	
	Agency/Organization	Position Held	Hrs./Week	Dates E		
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1. 2	Agency/Organization	Position Held	Hrs./Week	Dates Er		
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1. 2	Agency/Organization NYS Licensure: □ LMSW	Position Held	Hrs./Week	Dates Er		
1. 2 3	Agency/Organization NYS Licensure: □ LMSW Other Certifications:	Position Held	Hrs./Week	Dates En		
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	<u>Membership Level (</u> Please cire	cle one)					
	Member/Fellow170.00						
	Student I (While in MSW training and for one year after MSW graduation)48.00						
	Student II (2^{nd} and 3^{rd} year after MSW graduation and enrolled as a prior Student I)120.00 (renewal only)						
	Sustaining (meeting all requir	ements of the Member/	Fellow/Dip	olomate level- 1	no income)30	0.00	
	Affiliate (does not meet the requirements of Member, but supports the society)120.00						
	Corresponding (Primary mem	ber of another Society f	or Clinical S	Social Work)	.65.00 Primary	y Organization	
	Senior (70 years or older with	15 years of continuous	membershij	with the socie	ety)100.00		
	To assist with recruitment,	please explain why you	are joining	NYSSCSW an	d how you hear	rd about us:	
I	Affirmation: I affirm th I agree to be bound by the N	at the information detai		ı true account o	of my training :	and experience.	
ıatı	ıre:			Date:			
		APPLICANTS APPLY					
	Post-Master's Clinical Train	ning: (indicate either a c	ertification	from an institu	te or details of	75 hours Post Master's	
sev	work, not including workshop						
	School	Address	Γ	D ates	Cou	rse or Certificate	
1							
3							
	Supervision: (Complete only	if you do not have the '	'R" Credent	ial from NYS)			
	Name In	nstitution or Professio	nal Affiliat	ion	Dates	Total # Hours	
1.							
2							
3							
	If you do not have the "R" o	r "BCD" have you had p	ersonal ana	lysis or psycho	therapy? □ Y	es □ No	
		Pate Ended	#Hours/				
		AL	L APPLIC	ANTS			
	Please make checks payable	to New York State Soci	iety for Cli	nical Social W	ork and mail v	with the completed forn	
		243 Fifth Ave., Suit	•			_	
	An application using a cre	•	ŕ	•		5-9582.	
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		COMPLETED FORM 8					
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