



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 \$184.00 (You Save \$45 off Regular Cost) * Make Check Payable to AMHCA * You may also join online at www.amhca.org	Mail to: AMHCA c/o Wachovia Bank P O Box 758717 Baltimore, MD 21275
<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