



New York State Society for Clinical Social Work, Inc.

55 Harristown Rd, Suite 106

Glen Rock, NJ 07452

Tel: (800) 288-4279; Email: info.nysscsw@gmail.com; Fax: (718) 785-9582

Website: www.nysscsw.org; Facebook: www.facebook.com/NYSSCSW/info

MEMBERSHIP APPLICATION

NAME: _____ D.O.B.: _____

E-mail Address: _____

Home Address: _____ Zip: _____ Phone: _____

Private Address: _____ Zip: _____ Phone: _____

Agency/Institute/University: _____

Address: _____ Zip: _____ Phone: _____

New York State LCSW #: _____ New York State LP#: _____

New York State LMHC #: _____ New York State LMFT #: _____

Please check Preferred Mailing Address: Agency Private Practice Home

I Academic Training: (Start with Graduation Social Work School)

School	Address	Major	Degree	Year
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

II. Post Master's Experience: Agency, Clinic, Private (Start with most recent position)

Agency/Organization	Position Held	Hrs./Week	Dates Employed
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

III. NYS Licensure: LMSW LCSW R Credential

Other Certifications: _____

IV Professional Liability (malpractice) Insurance: Yes No

Carrier: _____

V Membership Level (Please circle one)

- Member/Fellow ... 170.00
- Student I (While in MSW training and for one year after MSW graduation)... 48.00
- Student II (2nd and 3rd year after MSW graduation and enrolled as a prior Student I)... 120.00
- Affiliate (does not meet the requirements of Member, but supports the society)... 120.00
- Platinum (70 years or older with 15 years of membership with the society)... 100.00

OVER

VI Chapter Affiliation: Please check one.

(Applicant will be placed on Mailing List/List Serve for Selected Chapter)

- Metropolitan (Manhattan & Bronx) Mid-Hudson Nassau Queens
 Rockland Suffolk Staten Island Westchester

VII To assist with recruitment, please explain why you are joining NYSSCSW and how you heard about us:

VIII Affirmation: I affirm that the information detailed here is a true account of my training and experience.
I agree to be bound by the NYSSCSW Code of Ethics.

Signature: _____ Date: _____

APPLICANTS APPLYING FOR FELLOW STATUS ONLY

A. Post-Master's Clinical Training: (indicate either a certification from an institute or details of 75 hours Post Master's coursework, not including workshops, seminars, or conferences.)

School	Address	Dates	Course or Certificate
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

B. Supervision: (Complete only if you do not have the "R" Credential from NYS)

Name	Institution or Professional Affiliation	Dates	Total # Hours
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

C. If you do not have the "R" or "BCD" have you had personal analysis or psychotherapy? Yes No

Date Begun	Date Ended	#Hours/Week
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Please check any ADDITIONAL listservs you would like to be added to – Please note EACH addition is \$25 per listserv

- METROPOLITAN MID HUDSON NASSAU/SUFFOLK QUEENS ROCKLAND
 STATEN ISLAND WESTCHESTER

ALL APPLICANTS

Please make checks payable to New York State Society for Clinical Social Work and mail with the completed form to
55 Harristown Rd, Suite 106; Glen Rock, NJ 07452

An application using a credit card (Visa or MasterCard) may be faxed to 1-718-785-9582.

Name on card: _____

Card number: _____ Expiration Date: _____

CVV: _____ Billing Zip Code: _____