



Philadelphia Society of Clinical Psychologists

Associate Member Application

1. Name: _____

2. Home Address and Telephone: _____

3. E-mail Address: _____

4. Profession or Field of Employment: _____

5. Primary Place of Employment: _____

6. Work Address and Telephone: _____

7. Title of Position: _____

8. Please briefly explain the nature of your involvement with the field of Psychology:
(For example, do you teach a Psychology class? Are you a psychotherapist? Do you practice
mental health law?)

9. Highest (or most Relevant) Degree Earned: _____

Subject Area: _____

Degree Granting Institution: _____

10. Do you hold a professional license or certification? Yes No

If yes, what type of License/Certification? _____

Year of Licensure/Certification: _____ State of Licensure: _____

I certify that the information given by me in support of this application is true and correct.

Signature: _____ Date: _____

Please mail application enclosed with a check for \$90 payable to "PSCP" to:

Philadelphia Society of Clinical Psychologists

601 Summit Avenue, 2nd Floor

Jenkintown, PA 19046

If you have any questions, please contact Christine Waanders, Membership Chair, at 215-885-2562.