DELAWARE PROFESSIONAL COUNSELORS ASSOCIATION
MEMBERSHIP APPLICATION

NAME: ______________________ ______________________ ______ ______________________
Last First Initial Credentials

______________________________________ ______________________________
MAILING ADDRESS CITY, STATE, ZIP

PHONE: ______________________ E-MAIL: ______________________________

May this information be shared with DPCA members? Yes ____ No ____ Keep Confidential ____

ACTIVE MEMBER OF ACA ______ AMHCA ______

MEMBERSHIP APPLYING FOR: (Dues good - July 2011 through **June 2012**)

Clinical $40.00 ____ Professional $40.00 ____ Student $10.00 ____
Associate $20.00 ____ Retired $20.00 ____ University ______________

Please make check payable to **DPCA**
and return with application to:

DPCA
c/o María del C. Martínez, LPCMH
PO Box 7715
Newark, DE 19714

Questions may be directed to:

María del C. Martínez
(302) 893-1349
mariawithanaccent@msn.com

MEMBERSHIP REQUIREMENTS PER CURRENT BY-LAWS

Clinical Members

Applicants for clinical membership shall certify that they are licensed in Delaware as an LPCMH or LACMH in good standing. At the discretion of the Board of Directors individuals who are licensed as a Psychologist, Clinical Social Worker, Marriage and Family Therapist, or Chemical Dependency Professional may apply as Clinical Members.

Professional Member

Applicants for professional membership shall certify that they have a Master's degree or higher in counseling or a related field covering the basic principles of professional counseling (as defined by the DPCA Board) from a regionally accredited institution.

Retired Members

Members in retirement shall be entitled to reduced annual dues and shall maintain all the privileges of clinical/ professional membership.

Student Members

Individuals enrolled as a student in good standing in a regionally accredited graduate program in counseling or a related area that covers the basic principles of professional counseling.

Associate Members

Any person whose primary work-related responsibilities are in the area of counseling or a related field shall be eligible for associate membership in the association.

FOR DPCA USE ONLY:

Amount Paid ________ Rcv'd __________ Cash Receipt /Ck # __________ Entered DB ______________

(Rev. 1/2012)

DELAWARE PROFESSIONAL COUNSELORS ASSOCIATION

Member's Practice Information, if applicable

NAME: ______________________ ______________________ ______ ______________
Last First Initial Credentials

ORGANIZATION: (note agency's name if applicable)

WORK ADDRESS CITY, STATE, ZIP

PHONE/s: ______________________ FAX: ______________

E-MAIL: ______________________

States in which you are licensed ____ ____ ____ ____ Years of experience ____

Work setting:

Independent practitioner in group practice ____ Individual Practice ____

Practitioner within group / agency setting ____ Other ______________

Please note if you work with the following populations:

Children (please note ages) ____ Adults ____ Elderly ____

Adolescents (please note ages) ____ Couples ____ Hearing impaired ____

Family Therapy ____ Language/s other than English (please note): ______________

Please note issues you work with:

Anxiety	____	Eating disorders	____	Life transition/Coaching	____	Axis II	____
Acute stress	____	Dissociative disorders	____	Mediation counseling	____	OCD	____
Bi-Polar	____	Sexual trauma	____	Developmental disabilities	____	PTSD	____
Depression	____	Sexual issues	____	Schizophrenia/Psychotic disorders	____	Dual diagnosis	____
Phobia	____	Somatic disorders	____	Anger/impulse control	____		
Perpetrators	____	Substance abuse	____	Other addictions (please specify)	______________		

Others (please note) ______________________

Please note theoretical approaches / treatment modalities or specific protocols utilized in your practice (i.e, mbsr):

Please list insurance's and EAP's for which you are an in-network provider: ______________

Please check if you are willing to participate as board member of DPCA. Y N

Please check if you are willing to participate in any of these committees as a member Y N

Advocacy ____ Consultation/Mentoring ____ Education ____ Membership/Outreach ____ Monitoring ____

Please note if you are willing to provide mentoring or consultation to students / newcomers Y N

If available for presentations please note topics ______________________

(Rev. 1/2012)