

Fort Worth Area Psychological Association

fwapa@fwapa.org

P.O. Box 471432

Fort Worth, Texas 76147-1376

Membership Application/Renewal 2012

PERSONAL INFORMATION (For FWAPA use only)

Name: _____ Degree _____

Home Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Web Address: _____

PRACTICE INFORMATION (Available to public with higher tier membership)

Office Address: _____

Suite/Apt. # _____ City: _____ State: _____ Zip: _____

Office Phone #: _____

Email: _____ Web Address: _____

Make email public? ___Yes ___No

Make Web Address Public? ___Yes ___No

MEMBERSHIP INFORMATION (Please circle all that apply.)

1. Are you presently licensed by TSBEP? No Yes License # _____
2. Are you a current member of TPA? No Yes
3. Are you a current member of APA? No Yes

Membership Dues (Please check the Membership category you are applying for):

___ Member \$50.00 (Voting Member)

“Members of this Association must be Doctoral level psychologists who are currently licensed by TSBEP, or Fellow or doctoral level member of the American Psychological Association or the Texas Psychological Association.” Check all that apply.

_____ Licensed Psychologist

_____ Provisionally Licensed Psychologist

_____ Licensed Specialist in School Psychology (doctoral degree)

_____ Fellow or doctoral level member of APA or TPA

___ Associate Member \$50 (Non-Voting Member)

“Associate members shall be persons who do not meet criteria for membership but have interest in the organization and are supportive of its purposes.”

_____ Licensed Psychological Associate

_____ Licensed Specialist in School Psychology (masters degree)

_____ Mental health professional

_____ Friend of FWAPA

_____ Post-doc

___ Student Affiliate - Free (Non-Voting Member)

___ Retired Psychologist - Free (Non-Voting Member) Doctoral level psychologists who have retired their license in good standing from the appropriate state licensing board.

2012 Application form for FWAPA's Web-based referral service

Secondary Practice Location

Name of Secondary Practice: _____

Secondary Practice Phone #: _____

Secondary Practice Address: _____

Suite/Apt. #: _____ City: _____ State: _____ Zip: _____

For Deluxe Membership please provide your website address:

Prospective clients will use these areas in their search for a psychologist.

Please select all that apply to you.

Specialty/Services Focus	
<input type="checkbox"/> Acceptance and Commitment Therapy (ACT)	<input type="checkbox"/> Hypnosis
<input type="checkbox"/> Attention Problems/ADHD	<input type="checkbox"/> Industrial/Consulting
<input type="checkbox"/> Anger Management	<input type="checkbox"/> Learning Disability
<input type="checkbox"/> Anxiety /Stress	<input type="checkbox"/> Marriage/Relationship
<input type="checkbox"/> Biofeedback	<input type="checkbox"/> Medical Problems/Pain
<input type="checkbox"/> Bipolar/Schizophrenia	<input type="checkbox"/> Motivational Interviewing
<input type="checkbox"/> Borderline Personality	<input type="checkbox"/> Neuropsychology/Brain Injury
<input type="checkbox"/> Career counseling/Testing	<input type="checkbox"/> Panic/Phobia
<input type="checkbox"/> Children's Problems	<input type="checkbox"/> Play Therapy
<input type="checkbox"/> Child custody	<input type="checkbox"/> Post Traumatic Stress
<input type="checkbox"/> Cognitive Behavioral Therapy (CBT)	<input type="checkbox"/> Psychodynamic Therapy
<input type="checkbox"/> Dialectical Behavior Therapy (DBT)	<input type="checkbox"/> School Problems
<input type="checkbox"/> Depression	<input type="checkbox"/> Sexual Problems
<input type="checkbox"/> Dissociative Disorders	<input type="checkbox"/> Sign Language
<input type="checkbox"/> Eating Disorder/Weight	<input type="checkbox"/> Sliding Scale Fee
<input type="checkbox"/> Eye Movement Desensitization and Reprocessing (EMDR)	<input type="checkbox"/> Smoking Cessation
<input type="checkbox"/> Family Problems	<input type="checkbox"/> Spanish Speaking
<input type="checkbox"/> Gambling	<input type="checkbox"/> Spiritual Issues
<input type="checkbox"/> Lesbian/Gay/Bisexual/Transgender (LGBT)	<input type="checkbox"/> Substance Abuse/Alcohol
<input type="checkbox"/> Grief	<input type="checkbox"/> Testing/Evaluation/Assessment
<input type="checkbox"/> Group Therapy	<input type="checkbox"/> Worker's compensation

Please list up to 10 insurance panels for which you provide service:
