



MEMBERSHIP APPLICATION

PLEASE TYPE OR PRINT

Name: (Last) _____ (First): _____ MI. _____

Address: _____ Suite: _____ City: _____ Zip: _____

Telephone: _____ Fax: _____

If you have a other address please check both locations below and list address at bottom of last page.

Location: ___ North Naples ___ East Naples ___ South Naples ___ Old Town/Downtown
 ___ Bonita Springs ___ Immokalee ___ Marco Island ___ Ft. Myers

E-Mail Address (for MHASWFL use only): _____

License # _____

Degree(s) _____ What University _____

Degree(s) _____ What University _____

Theoretical Orientation _____

Languages Spoken (Other than English) Please circle : Creole Danish French German Greek Hebrew Hungarian Japanese Polish Portuguese Spanish Yiddish Other _____

Handicapped Accessible: () Yes () No

FEES:

Initial Consultation Fee: _____ Insurance Assignment () Yes () No

Follow-up Treatment Fee: _____ Medicare () Yes () No

Group Fee: _____ Medicaid () Yes () No

Fee Adjustment () Yes () No Florida's Healthy Kid Care () Yes () No

Managed Care () Yes () No

AREAS OF INTEREST

Populations Served:

() Children () Adolescents () Adult () Geriatrics () Couples () Families

Which populations do you serve?

() Individual () Family () Couple () Group () In-patient () Out-patient

Please select TEN or fewer areas of interest so we can make informed referrals.

DESIGNATE YOUR TOP THREE AREAS BY NUMBERING

- | | |
|--|--|
| <input type="checkbox"/> Addictive Behaviors | <input type="checkbox"/> Marriage & Family/Relationships |
| <input type="checkbox"/> Adjustment Disorders | <input type="checkbox"/> Men's Issues |
| <input type="checkbox"/> Adopted Children & Families | <input type="checkbox"/> Neuropsychiatry |
| <input type="checkbox"/> Affective Disorders | <input type="checkbox"/> Neuropsychology |
| <input type="checkbox"/> Anxiety Disorders | <input type="checkbox"/> Pervasive Developmental Disorders |
| <input type="checkbox"/> Attention Deficit & Disruptive Behavior Disorders | <input type="checkbox"/> Personality Disorders |
| <input type="checkbox"/> Behavioral Medicine/Chronic Pain & Illness | <input type="checkbox"/> Pharmacologic Treatment |
| <input type="checkbox"/> Crisis Intervention/Critical Incident Stress Debriefing | <input type="checkbox"/> Play Therapy |
| <input type="checkbox"/> Dementia/Alzheimer's | <input type="checkbox"/> Psychological Testing |
| <input type="checkbox"/> Diagnostic Evaluation | <input type="checkbox"/> School/Educational Issues |
| <input type="checkbox"/> Forensic Assessment | <input type="checkbox"/> Sexual Dysfunctions |
| <input type="checkbox"/> Forensic Treatment/Offenders & Perpetrators | <input type="checkbox"/> Sexual Abuse/Incest |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Spirituality |
| <input type="checkbox"/> Grief / Bereavement | <input type="checkbox"/> Therapy for Therapists |
| <input type="checkbox"/> Hypnotherapy | <input type="checkbox"/> Tic Disorders |
| <input type="checkbox"/> Impulse Control Disorders | <input type="checkbox"/> Violence /Abuse/ Perpetrators |
| | <input type="checkbox"/> Violence /Abuse/ Victims |
| | <input type="checkbox"/> Vocational / Industrial Issues |
| | <input type="checkbox"/> Women's Issues |

SPECIAL CERTIFICATION / OTHER TRAINING:

PLEASE PROVIDE DOCUMENTATION OF SPECIAL CERTIFICATION / OTHER TRAINING

- | | |
|--|--|
| <input type="checkbox"/> Addictions | <input type="checkbox"/> Medical Psychotherapy |
| <input type="checkbox"/> Behavioral Medicine | <input type="checkbox"/> Ministerial Counseling |
| <input type="checkbox"/> Bereavement | <input type="checkbox"/> Music Therapy |
| <input type="checkbox"/> Biofeedback | <input type="checkbox"/> Pain Management |
| <input type="checkbox"/> Board Certified Child Psychiatry | <input type="checkbox"/> Play Therapy |
| <input type="checkbox"/> Board Certified Adolescent Psychiatry | <input type="checkbox"/> Poetry Therapy |
| <input type="checkbox"/> Board Certified Adult Psychiatry | <input type="checkbox"/> Psychodrama |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Psychotherapy |
| <input type="checkbox"/> Clinical Supervision | <input type="checkbox"/> Psychopharmacology |
| <input type="checkbox"/> Cognitive-Behavioral Therapy | <input type="checkbox"/> Rape Counseling |
| <input type="checkbox"/> Critical Incident Stress Management | <input type="checkbox"/> Reality Therapy |
| <input type="checkbox"/> Disabilities | <input type="checkbox"/> Rehabilitation Counseling |
| <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Reproduction Medicine |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Relapse Prevention |
| <input type="checkbox"/> EMDR | <input type="checkbox"/> School Psychology |
| <input type="checkbox"/> Employee Assistance | <input type="checkbox"/> Sex Therapy |
| <input type="checkbox"/> Expressive Therapy | <input type="checkbox"/> Spiritual Eldering |
| <input type="checkbox"/> Forensics | <input type="checkbox"/> Sports Psychology |
| <input type="checkbox"/> Hypnosis | <input type="checkbox"/> Substance Abuse/Alcohol |
| <input type="checkbox"/> IMAGO Therapy | <input type="checkbox"/> Tobacco Addiction |
| <input type="checkbox"/> Marriage/Family Therapy | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Managed Care | <input type="checkbox"/> Workers' Compensation |
| <input type="checkbox"/> Mediation | <input type="checkbox"/> Other: _____ |

Client Population Served:

1. Check the client population you serve:
(Rank in order 1st, 2nd, 3rd, 4th)

Individual____ Family____ Group____ Marital/Couple____

2. What percentage of your current client population is made up of the following age classifications?

Children (ages 1 to 4) _____%
(ages 5 to 11) _____%

Adolescents (ages 12 to 17) _____%

Adults (ages 18 to 59) _____%

Geriatrics (ages 60+) _____%

THE MHASWFL NEEDS YOUR HELP:

- ✓ Would you offer pro bono services to a referral from the MHASWFL for up to twelve sessions? Yes () No ()

For: Children () Adolescents () Adults () Geriatrics () Couples () Families ()

- ✓ Would you be interested in participating in the MHASWFL CEU Program? Yes () No ()

If Yes, please list topics of interest: _____

✓

- ✓ Would you be willing to join the MHASWFL Speakers Bureau?

Yes () No () If Yes, please list topics of interest: _____

- ✓ Would you teach the Putting Children First / Families in Transition divorce education program provided by MHASWFL?

Yes () No ()

✓ Would you facilitate a support group for MHASWFL? Yes () No ()

If yes, please list areas of interest: _____

✓ Would you write articles for our quarterly new letter? Yes () No ()

If yes, please list areas of interest: _____

PLEASE RETURN TO:

Mental Health Association of Southwest Florida

2335 Tamiami Trail North Suite 404

Naples, FL 34103

Phone: 261-5405 Fax: 261-2931

Please provide secondary professional address here:

Address: _____ Suite: _____ City: _____ Zip: _____

Telephone: _____ Fax: _____