The Virginia Society for Clinical Social Work, Inc.
2018-19 New Membership Form

Membership Year July 1, 2018 - June 30, 2019

http://www.vscsw.org or vscsw1976@verizon.net

Office Use Only:
Chapter _____
Mailings _____
Credit Card Approval _____
Certificate Mailed _____
Directory Sent _____

- Please use this form if you have never been a VSCSW member, or if your membership has lapsed for over 1 year
- Please mail form and dues to **VSCSW *(Membership) 10106-C Palace Way* Henrico, VA 23238**

Indicate Membership Category for which you are eligible:								Dues
☐	**Full** (Active LCSW in good standing – PLEASE ENCLOSE A PHOTOCOPY OF YOUR LICENSE)							$150
	Highest Graduate Degree		Year		School Name			
	Other States which you are licensed							
☐	**Associate** (MSW without Virginia license)							$115
☐	**New Professional** (New MSW applying 6 months after graduation for a 1-year period only)							$70
☐	**Student** (Current full-time student in a Masters or Doctoral Clinical Social Work Program)							$65
	School Name							
	Anticipated Degree		Expected Graduation Date		Student ID #			
☐	**Affiliate** (Retired from practice, or out-of-state resident)							$95
	Date of Retirement		Residing in which state?					
☐	**(Optional) Donation to the VSCSW Lobbyist Fund** (specify the amount)							$
PAYMENT	If paying by check, make all checks payable to VSCSW. The check # is							Total
	If paying by Master Card or Visa:	Name as it appears on Card						$
		Card Number						
		Exp Date		3 Digit Code on Back				
		Signature (must be signed)						

Affirmation: By submitting this application, I affirm that the above information is a true account of my training and experience, and I agree to be bound by the CSWA Code of Ethics. I also agree with the purposes of the VSCSW to:

- Promote the highest standards of professional education and clinical social work practice;
- Promote clinical social work throughout the State through the formation of local chapters;
- Coordinate the activities of all the chapters;
- Educate the public of the specialized skills of clinical social workers;
- Collaborate with other health/mental health care professions on issues of common concern;
- Protect the rights of clinical social workers to practice; and
- Advocate for adequate and appropriate mental health services and insurance coverage at the state and national levels.

I also understand that current members of the Society are required to notify the President of the Society of any Disciplinary Order by the VA Board of Social Work within 30 days. The president at their discretion, may take no action, suspend, or terminate the LCSWs membership in the society.

Type Name:		Date:	
Signature:			

Who recommended or referred you to join the Society?			
☐	Your MSW Program or Faculty	☐	Your Agency or Clinical Supervisor for Licensure
☐	A Web Search or the vscsw.org website	☐	**VSCSW Member** (Name Credit:)

(Please complete both sides of this form)

Directory Information

Please fill out ALL information as we need to check to make sure what is on file is current and up-to-date.

Home Address Information		Check all that apply		E-Mail Address: (Membership votes and notices sent by email)	
Name		☐	MSW		
Street		☐	LCSW	Please indicate which chapter you belong to: (NOTE: You may select the Chapter, it is not restricted by geographical boundaries)	
City		☐	Ph.D.		
State		☐	BCD	**Blue Ridge**	☐
Zip		[redacted]		**Eastern Virginia**	☐
Phone				**Richmond**	☐
Please check your preference for mailings:	☐ HOME	☐ OFFICE		**Roanoke**	☐

FIRST WORK ADDRESS		SECOND WORK ADDRESS	
NAME		**NAME**	
STREET		**STREET**	
CITY		**CITY**	
STATE		**STATE**	
ZIP CODE		**ZIP CODE**	
PHONE		**PHONE**	
FAX		**FAX**	

CLINICAL PRACTICE INFORMATION - OPTIONAL

(This information will be listed in the directory, check all that apply)

Practice Populations				Specific Areas of Expertise
☐	Children	☐	Individuals	
☐	Adolescents	☐	Couples	
☐	Adults	☐	Families	
☐	Geriatrics	☐	Groups	
☐	**Check here if you currently provide LCSW Supervision to MSWs pursing licensure; and meet the requirements of the VBSW regulations 18VAC140-20-50, B.2. By checking here you give permission to VSCSW to share your name and contact info with membership, especially New Professional and Associate members, as a provider of LCSW Supervision.**			

I would be interested in active participation with the following Society activities:					
☐	**Conference**	☐	**Education**	☐	**Fundraising**
☐	**Legislative**	☐	**Membership**	☐	**Mentoring**
☐	**Newsletter**	☐	**Public Relations**	☐	**Serve on local or state VSCSW Boards**