

The Virginia Society for Clinical Social Work, Inc.
2020-21 Membership Form

Membership Year July 1, 2021 - June 30, 2022

vscsw1976@gmail.com or www.vscsw.org

| |
|----------------------------|
| Office Use Only: |
| Chapter _____ |
| Mailings _____ |
| Credit Card Approval _____ |
| Certificate Mailed _____ |
| License Verification _____ |

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) 1261 Abingdon Road, North Chesterfield, VA 23236**

***This year VSCSW is offering a special Covid-19 Hardship Rate on Full Memberships to those who need it. Simply pay \$115 (instead of the \$150) and **please note Covid-19 in your memo line, so still know that it is a Full Membership.**

| Indicate Membership Category for which you are eligible: | | | | | | | Dues |
|--|--|--|--------------------------|--|--------------|--|-------------|
| <input type="checkbox"/> | 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 | | | | | | |
| <input type="checkbox"/> | Associate (MSW without Virginia license) | | | | | | \$115 |
| <input type="checkbox"/> | New Professional (New MSW applying 6 months after graduation for a 1-year period only) | | | | | | \$70 |
| <input type="checkbox"/> | Student (Current full-time student in a Masters or Doctoral Clinical Social Work Program) | | | | | | \$65 |
| | School Name | | | | | | |
| | Anticipated Degree | | Expected Graduation Date | | Student ID # | | |
| <input type="checkbox"/> | Affiliate (Retired from practice, paraprofessional, or out-of-state resident) | | | | | | \$95 |
| | Date of Retirement | | Residing in which state? | | | | |
| <input type="checkbox"/> | (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 \$ |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

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? | | | |
|--|---------------------------------------|--------------------------|--|
| <input type="checkbox"/> | Your MSW Program or Faculty | <input type="checkbox"/> | Your Agency or Clinical Supervisor for Licensure |
| <input type="checkbox"/> | A Web Search or the vscsw.org website | <input type="checkbox"/> | 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 | | | | <input type="checkbox"/> | MSW | | |
| Street | | | | <input type="checkbox"/> | LCSW | Please indicate which chapter you belong to: (NOTE: You may select the Chapter, it is not restricted by geographical boundaries) | |
| City | | | | <input type="checkbox"/> | Ph.D. | | |
| State | | | | <input type="checkbox"/> | BCD | | |
| Zip | | | | | | Blue Ridge | <input type="checkbox"/> |
| Phone | | | | | | Eastern Virginia | <input type="checkbox"/> |
| Please check your preference for mailings: | | <input type="checkbox"/> | HOME | <input type="checkbox"/> | OFFICE | Roanoke | <input type="checkbox"/> |

| 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 | |
|--------------------------|--|--------------------------|-------------|-----------------------------|--|
| <input type="checkbox"/> | Children | <input type="checkbox"/> | Individuals | | |
| <input type="checkbox"/> | Adolescents | <input type="checkbox"/> | Couples | | |
| <input type="checkbox"/> | Adults | <input type="checkbox"/> | Families | | |
| <input type="checkbox"/> | Geriatrics | <input type="checkbox"/> | Groups | | |
| <input type="checkbox"/> | Check here if you currently provide LCSW Supervision to MSWs pursuing 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: | | | | | |
|--|-------------|--------------------------|------------------|--------------------------|--------------------------------------|
| <input type="checkbox"/> | Conference | <input type="checkbox"/> | Education | <input type="checkbox"/> | Fundraising |
| <input type="checkbox"/> | Legislative | <input type="checkbox"/> | Membership | <input type="checkbox"/> | Mentoring |
| <input type="checkbox"/> | Newsletter | <input type="checkbox"/> | Public Relations | <input type="checkbox"/> | Serve on local or state VSCSW Boards |