

NEW YORK STATE SOCIETY FOR CLINICAL SOCIAL WORK, INC.

# 1800 288 4CSW

MEMBERSHIP APPLICATION

NAME: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Email Address: \_\_\_\_\_

Home Address: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Private Practice: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Agency: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Please Circle Preferred Mailing Address:                      Agency                      Private Practice                      Home

I Academic Training: (Start with Graduate Social Work School)

	<b>School</b>	<b>Address</b>	<b>Major</b>	<b>Degree</b>	<b>Year</b>
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____

II Post Master's Experience: Agency, Clinic, Private (Start w/ most recent position)

	<b>Agency/Organization</b>	<b>Position Held</b>	<b>Hrs./Week</b>	<b>Dates Employed</b>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

III NYS Licensure:                      LMSW                      LCSW                      R Credential

Other Certifications: \_\_\_\_\_

IV Professional Liability (malpractice) Insurance:                      Yes                      No

Carrier: \_\_\_\_\_

V. Chapter Affiliation: Please circle one. (Applicant will be placed on Mailing List/List Serve for Selected Chapter)

Brooklyn                      Nassau                      Syracuse                      Suffolk                      Queens                      Rockland  
Metropolitan (Manhattan & Bronx)                      Mid Hudson                      Westchester                      Staten Island  
Not Currently Active:                      Capital District (Albany)                      Western N.Y.

VI. To Assist with recruitment, please explain why you are joining NYSSCSW and how you heard about us:

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VII. Affirmation: I affirm that the information detailed here is a true account of my training and experience. I agree to be bound by the NYSSCSW Code of Ethics.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**APPLICANTS APPLYING FOR FELLOW STATUS ONLY**

A. Post Master's Clinical Training (indicate either a certificate from an institute or details of 75 hours Post Master's coursework, not including workshops, seminars, or conferences.)

School	Address	Dates	Course or Certificate
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____

B. Supervision: (Complete only if you do not have the "R" Credential from NYS)

Name	Institution or Professional Affiliation	Dates	Total # Hours
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____

C. If you do not have the "R" or "BCD" have you had personal analysis or psychotherapy?      Yes      No  
Date Begun      Date Ended      # Hours/Week

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**ALL APPLICANTS**

Please refer to Following Pages for Details on Membership and Fees  
Make checks payable to NYS Society for Clinical Social Work.

Please Mail Completed Form & Payment to Address at top of Application