2010 MEMBERSHIP
NEW AND RENEWAL
CVMHPA

Conejo Valley Mental Health Professionals Association

Your membership will become effective upon receipt of this application and will be valid through 12-31-2010. If you have completed this form since July 1, 2009 please disregard. **To be included in the 2010 CVMHPA Membership Directory, applications must be postmarked no later than 12-31-09.**

(Please print clearly)

Name: ____
(First) (Middle Initial) (Last)

Business Address: ____
(Street) (Suite)

____
(City) (State) (Zip Code)

Business Telephone: ( ) ____________ **Fax:** ( ) ____________ **E-Mail:** ____________________

Mailing Address: ____ (If different from above)
(Street) (Suite)

____
(City) (State) (Zip Code)

Home Phone Number (Optional): ( ) ____________________

Cell Phone Number (Optional): ( ) ____________________

Please indicate your license number(s) beside the appropriate title(s) listed below:

Psychiatrist	Clinical Social Worker
Psychologist	Marriage and Family Therapist

Allied Professional or other ____
(Please indicate profession and license number as applicable)

Unlicensed Members ____
(Please indicate title and number as applicable)

Would you be interested in learning about or participating in one or more of the following committees?

	Historian/Memory Book		Marketing		Prelicensed Interest
	Hospitality		Membership		Programs/Continuing Education
	Mailings		Newsletter		Website
Other					

Would you be interested in learning about or participating in one or more of the following interest groups?

	Meet and Greet (various topics presented by our members)		Mind/Body/Spirit Approaches to Healing		Consultation Group with Ed Jesalva, M.D.
Other					

Dues: Annual dues for membership are **$60.00** for licensed professionals and **$35.00** for students, trainees and interns. Students, trainees and interns must have a sponsor who is a member. Please make checks payable to **CVMHPA** and mail to **Conejo Valley Mental Health Professionals Association, 4165 W. Thousand Oaks Blvd., Suite 345, Westlake Village, CA 91362.** If you have any questions, please visit our website at www.cvmhpa.org. There you will find email addresses for all chairpersons.

I hereby apply to the Conejo Valley Mental Health Professionals Association for membership. I, the applicant, certify that the information in this application correctly represents my qualifications. I understand that if it does not, my membership may be voided. I will notify the Association of any changes in this information. I understand that the Conejo Valley Mental Health Association is an interest group only, will not provide referrals, and does not credential its members in any way. I understand that to be a Full Member, I must be in good standing with my state licensing board. I understand that if I am a student or intern, I must have a **licensed member** of the Conejo Valley Mental Health Professionals Association sponsor me.

____

Applicant's Signature **Date**

Student/Intern's sponsor name and signature (If applicable):

____

Sponsor's Name **Sponsor's Signature** **Date**

For office use only:
Payment received ________________ Date ____________
Form of payment: Cash ____________ Check number ______

OVER

Please complete the Directory Form on the reverse side to be included in the 2010 Membership Directory

2010 CVMHPA DIRECTORY FORM

The information on this form will be used for the next Conejo Valley Mental Health Professionals Association Directory. Please complete all the information that you want to be published in the directory.

If this is a renewal application, please complete this page even if there are no changes from last year.

Name____ Title (M.D., Ph.D., Psy.D., M.A., M.S.)__________ License or profession ______________
Business Address____
(Street) (Suite) (City) (State) (Zip)
Business Phone_____________________ Fax____________________ E-mail___________________________ Website________________________

*Please indicate **no more than four** specialties that you treat:*

___Abuse/Trauma/PTSD
___Addictions/Substance Abuse
___Anger Management
___Anxiety/Panic/OCD
___Attention Deficit/Hyperactivity
___Autism/Aspergers/Mental Retardation
___Bipolar Disorder
___Depression
___Divorce/Mediation
___Eating Disorders
___Elder Issues
___Gay/Lesbian Issues
___Grief/Loss
___Health Problems/Chronic Pain
___Impulse Control/Anger/Violence
___Job Related Concerns
___Marital/Premarital/Relationship
___Parenting Issues
___Personality Disorders
___Psychotropic Medication Management
___School/Behavior/Learning Disorders
___Sexual Problems

*Please indicate **no more than three** special services you provide:*

___Critical Incident Debriefing
___EMDR
___Hypnotherapy
___Life Coaching
___Mediation/Custody
___Psychological/Educational Testing
___Religious/Spiritual Counseling
____Other

Please indicate the populations that you treat:

___Adolescents
___Adults
___Children
___Couples
___Families
___Seniors

*Please indicate the insurance and managed care companies with whom you are **contracted**:*

___Aetna
___Anthem/Blue Cross
___Beech Street
___Blue Shield
___CHAMPUS/TriCare
___Cigna
___College Health IPA (CHIPA)
___Community Care Network (CCN)
___First Health
___Health Net
___Horizon Behavioral Health
___Human Affairs International (HAI)
___Integrated Health Plan
___Magellan
___Managed Health Network (MHN)
___MediCal
___Medicare
___PacifiCare
___United Behavioral Health (UBH)
___Value Options (VBH)
___Victims of Crime (VOC)
___Worker's Compensation Fund
___________________________Other
___________________________Other
___________________________Other
___________________________Other
___________________________Other

Please note any groups that you lead: ____
____

Please note any languages spoken (other than English): ____

☐ Include this information on the CVMHPA Website ____
Signature

Please send completed form to: CVMHPA
4165 W. Thousand Oaks Blvd., Suite 345
Westlake Village, CA 91362
www.cvmhpa.org