INSTITUTE OF CLINICAL PSYCHOLOGISTS

MEMBERSHIP APPLICATION FORM

I am applying for : FULL MEMBERSHIP ASSOCIATE MEMBERSHIP

1. PERSONAL DETAILS

TITLE :
SURNAME :
GIVEN NAMES :
DATE OF BIRTH :

2. CONTACT DETAILS

POSTAL ADDRESS :

PRACTICE ADDRESS :

WORK TELEPHONE :
FAX :
HOME TELEPHONE :
MOBILE TELEPHONE :
EMAIL ADDRESS :

3. PSYCHOLOGISTS BOARD OF WA REGISTRATION DETAILS

TITLE	REGISTRATION NUMBER	DATE OF REGISTRATION
Clinical Psychologist		
Clinical Psychologist (Registrar)		

4. QUALIFICATIONS

DEGREE	INSTITUTION	GRADUATION YEAR

5. CURRENT MEMBERSHIPS OF PROFESSIONAL SOCIETIES

6. CURRENT CLINICAL PRACTICE

EMPLOYMENT	EMPLOYER	APPROX. TIME %
Private practice		
Private practice		
Non-private practice		
Non-private practice		

7. CURRENT CLINICAL PSYCHOLOGY WORK ACTIVITIES

8. PREVIOUS EMPLOYMENT AS A CLINICAL PSYCHOLOGIST

9. PROFESIONAL REFERREES

Please name two Clinical Psychologists (preferably ICP members) from whom information may be obtained regarding your character, ethical standing, professional competence, qualifications and experience.

NAME	ADDRESS

10. DECLARATION

The above information is true and correct. I agree to inform the ICP in writing should I ever wish to terminate my membership and that I will be responsible for all annual membership fees up to the end of the year in which I terminate my membership. I understand that the ICP is a voluntary organisation and does not offer a ***prorata*** fee structure at the time of commencing or terminating membership.

SIGNATURE OF APPLICANT : _____

DATE : _____

Please POST or FAX completed applications to:

Dr. Marjorie Collins
Psych Place
7 Willcock Street
ARDROSS WA 6153
Phone: (08) 9316 3422; Fax: (08) 9316 4474
Email: admin@psychplace.com.au