

# 2006 MEMBERSHIP APPLICATION

Please print clearly. This information will be used for our Membership Directory.  
See reverse side for instructions and mailing information.

## MEMBERSHIP TYPE (see reverse side for description)

Regular Member - \$45.00

Associate Member - \$45.00

Student Member - \$25.00

Membership year runs January 1st through December 31st, and will not be pro-rated nor carried over to the following Membership year.

## PERSONAL INFORMATION

FIRST NAME: \_\_\_\_\_ LAST NAME: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

TOWN/ST/ZIP: \_\_\_\_\_ COUNTY: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ HOME FAX: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

## EMPLOYMENT AND EDUCATIONAL INFORMATION

PLACE OF EMPLOYMENT: \_\_\_\_\_

TITLE: \_\_\_\_\_ BUSINESS PHONE: \_\_\_\_\_ BUSINESS FAX: \_\_\_\_\_

COLLEGE: \_\_\_\_\_ DEGREE: \_\_\_\_\_ YEAR: \_\_\_\_\_

Primary Work Setting: \_\_\_\_\_ Secondary Work Setting: \_\_\_\_\_  
(i.e. Hospital, School, Private Practice \*, University, Clinic/Agency) \*Private Practice must have a NYS License number listed below.

## PROFESSIONAL INFORMATION

NYS LICENSE: - (Y/N) Speech License # \_\_\_\_\_ Audiology License # \_\_\_\_\_

TEACHER CERTIFICATION: Teacher of Speech and Hearing Handicapped (TSHH) (Y/N)

Teacher of the Deaf (Y/N) Teacher of Students with Speech or Language Disabilities (TSSLD) (Y/N)

## PROFESSIONAL ASSOCIATIONS:

ASHA Specialty Recognition Status (Y/N)

ASHA Member (Y/N) Area of ASHA Recognition: \_\_\_\_\_

Speech Certified (Y/N) NYSSLHA Member (Y/N)

Audiology Certified (Y/N) American Academy of Audiology Member (Y/N)

(CONTINUED ON BACK)

I am qualified to perform evaluations/therapy in a foreign language (Y/N) Specify Language \_\_\_\_\_

Completion of Bilingual Extension Course: (Y/N) Date Completed Extension Course \_\_\_\_\_

Available for LISHA Committees (Y/N) Include your information on LISHA web site (Y/N)

Include name on lists sold to Speech/Language Companies & Affiliations only (Y/N)

Please complete, SIGN\*\* and return this form with a check payable to:  
LISHA, PO Box 133, Mastic Beach, New York 11951-0133

**\*\*\*ALL MEMBERS MUST SIGN THE FOLLOWING\*\*\***

\*\* I, \_\_\_\_\_, acknowledge that all editions of the LISHA Directory (previous and current) are **Confidential lists** of the Members of our Organization to be utilized by LISHA members solely as a resource of information to locate colleagues. **Directories are not to be used as a mailing list** for the intent and purpose of personal and/or professional financial gain, by our members, agencies, business partners or affiliated institutions without the written consent of the current LISHA Executive Board as stipulated on Page 16 of the 2004-2005 Directory. Furthermore, I understand that **misuse of the LISHA Directories will result in the immediate termination of my LISHA Membership and all its privileges for the current year.** Annual Dues will not be refunded. A penalty of \$250 for an unauthorized use will be enforced for agencies, business partners or affiliated institutions and any additional unauthorized use may be subject to a \$500 penalty.

**REGULAR MEMBER**

*(Please complete and sign all items on this form.)* Persons educated in speech science, speech-language and hearing rehabilitation and/or audiology, who meet one of the following professional standards; Clinical Certification by ASHA OR NYS Dept. of Ed. Certification as a Teacher of TSHH and degree in SLP or AUD, OR NYS licensed as SLP or AUD. (All membership privileges)

**ASSOCIATE MEMBER:**

*(Please complete and sign all items on this form)* Educators and other professional persons interested in the field of speech-language and hearing. (All membership privileges except that of voting and holding office.)

**STUDENT MEMBER:**

*(Please complete and sign all applicable items on this form.)* Undergraduate or graduate student, matriculating towards a degree and a verified letter from the Program Director, which must accompany this form. (All membership privileges except that of voting and holding office.)

**Student Members:** Please have the Program Director check box and sign below:

I verify that the student applicant is an undergraduate or graduate student, matriculating towards a Communication Sciences and/or Speech-Language Pathology and/or Audiology degree in our program.

Program Director and School: \_\_\_\_\_ Date: \_\_\_\_\_