



Long Island Speech-Language-Hearing Association

2012 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)

<input type="checkbox"/> Regular Member - \$50.00	<input type="checkbox"/> Associate Member - \$45.00	<input type="checkbox"/> Student Member - \$25.00** must have back signed by Program Director
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Membership year runs January 1st through December 31st, and will not be pro-rated nor carried over to the following Membership year.

DIRECTORY INFORMATION FOR ONLINE DIRECTORY

FIRST NAME: _____ LAST NAME: _____

TOWN/ST/ZIP: _____ COUNTY: _____ HOME PHONE: _____

If you do NOT wish to have the ABOVE information published in our directory please send your request to info@lisha.org

NON-PUBLISHED INFORMATION

MAILING ADDRESS: _____

CELL PHONE: _____ HOME FAX: _____ E-MAIL: _____

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.

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: American Academy of Audiology Member (AAA)# _____

ASHA Member # _____ NYSSLHA Member _____ (Y/N) ASHA Specialty Recognition Status _____ (Y/N)

Audiology Certified _____ (Y/N) Speech Certified _____ (Y/N) Area of ASHA Recognition: _____

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)

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 agree to abide by the Code of Ethics and Constitution of the Long Island Speech-Language-Hearing Association and 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 19 of the 2008-2009 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.

Signature of Applicant: _____ Date: _____

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:

- (1) Clinical Certification by the American Speech-Language-Hearing Association, or
- (2) New York State Department of Education Certification as a Teacher of the Speech and Hearing Handicapped (TSHH) or Teacher of Students with Speech-Language Disabilities (TSSLD) and must hold a degree in Speech-Language Pathology and/or Audiology, or
- (3) New York State License as a Speech-Language Pathologist or Audiologist
(All membership privileges)

ASSOCIATE MEMBER:

(Please complete and sign all items on this form.) Associate Members shall be educators and other professional persons interested in the field of speech-language and hearing. Individuals who are qualified to become a member in any other member classification may not henceforth qualify as an Associate Member. (All membership privileges except that of voting and holding office)

STUDENT MEMBER:

(Please complete and sign all applicable items on this form.) Undergraduates who have completed a minimum of nine (9) semester hours in speech-language pathology, audiology, or speech-language and hearing sciences, or matriculated towards a graduate degree in speech-language pathology, audiology, or speech-language and hearing sciences. Individuals who are qualified to become a member in any other member classification may not henceforth qualify as a Student Member. (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: _____