



Membership Application

Status (check one): New Membership _____ Membership Renewal _____

First Name _____ Last Name _____ Mental health degree _____

Mental health credential(s) _____ Affiliation _____

Job Title _____

Mailing Address _____

City _____ State _____ Zip Code _____ Country _____

Telephone (_____) _____ Email _____

Primary discipline: Counseling _____ Marriage & Family Therapy _____ Psychology _____ Social Work _____ Other _____

Primary workplace: Private Practice _____ Non-profit _____ Medical _____ Public Agency _____

K-12 School _____ College/University _____ Author/Presenter _____ Other: _____

Referred by (if applicable) _____

Member Category (check one): Dues include APT and Chartered Branch memberships.

Professional \$95 _____ (*individual US mental health professional*) If residing in DE, MT, NE, NV, or ND, dues are \$80.

International \$70 _____ (*individual non-US mental health professional*)

Affiliate \$50 _____ (*individual full-time student, parent, or other non-mental health professional*) If residing in DE, MT, NE, NV, or ND, dues are \$45.

\$ _____ .00 **Membership Dues**

\$ _____ .00 **Foundation Contribution** (*optional*) *Tax exempt support for play therapy research and promotion.*

\$ _____ .00 **Total Dues** (US dollars)

By submitting this membership application, I consent to receiving electronic communications from APT, and I acknowledge that consent can be withdrawn at any time by notifying APT in writing.

Check or Money Order payable to APT

Select one: Visa _____ MasterCard _____ Card Number _____

Expiration Date _____ AVS Code _____ (on back of card)

Signature _____