



Washington State Psychological Association

REFERRAL AGREEMENT

As a participant in WSPA's Information and Referral Service, I understand that I must meet the membership criteria and agree to the conditions of participation in the Service listed below:

1. I am currently licensed as a psychologist in the state of Washington.
2. I maintain professional liability insurance for the practice of psychology with a minimum coverage of at least \$1,000,000 per occurrence and \$3,000,000 aggregate. **(Please mail or email evidence of insurance, listing will NOT be activated until it is received in office).**
3. I agree to keep my membership dues current. I understand that my listing will not be placed in active status until all membership dues and fees and supporting documentations are received by the WSPA Business Office.
4. I further understand that any loss or suspension of my license will result in automatic and immediate deletion of my listing from the roster until my license is reinstated.
5. I agree to immediately notify the WSPA Business Office of any circumstances that would change my eligibility for inclusion in the Referral Service, and I understand that the following circumstances may be cause for removal of my name from the Service listing: a. Failure to maintain a current State of Washington psychologist license. b. Failure to maintain minimum professional liability insurance. c. Under formal review by the Washington State Examining Board of Psychology following issuance of a "Statement of Charges" to the psychologist. d. Sanctioned by the Washington State Examining Board of Psychology through issuance of a Board Order.
6. I understand that any restriction applied by the Washington State Examining Board of Psychology to my professional practice will be reflected in my listing until the restriction is removed.
7. I assume liability for any legal causes of action that may arise from use or involvement with the Service, and further, I waive any right or remedy in any legal cause of action against the Service for any acts or omissions or conduct constituting ordinary negligence on the part of the Service.
8. I understand that I may remove my name from the Service at any time, which I may do by giving written notice to the WSPA Business Office, or my name may be removed from the Service through an action of the Executive Board or Executive Committee.

By signing this Agreement, I indicate that I understand and agree to the conditions described herein.

Signature _____ Date _____

Print Name _____

Send Agreement Form and Insurance Verification to:

Washington State Psychological Association
9 S. Washington Suite 201 Spokane, WA 99201
or email to: WSPA@wapsych.org