

# ORTHO MEMBERSHIP FORM

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You can also renew your membership by completing the following form and e-mailing or faxing (if paying by credit card) or sending by mail (if paying by check) to:

**American Orthopsychiatric Association**  
c/o Institute on Family & Neighborhood Life, Clemson University  
225 S. Pleasantburg Drive, Suite B-11  
Greenville, SC 29607 USA  
FAX: 864-250-4668  
E-Mail: [lbailey@AOAToday.com](mailto:lbailey@AOAToday.com)

*Please use this opportunity to provide or update your contact information and field of study/professional interests.*

Member Name: \_\_\_\_\_

Profession/Credentials: \_\_\_\_\_

Organizational Affiliation: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### **Field of Study/Professional Interest:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Community/School Mntl Health | <input type="checkbox"/> Sexual/Reproductive Issues | <input type="checkbox"/> Marriage/Family   |
| <input type="checkbox"/> Immigration & Refugees       | <input type="checkbox"/> Inclusion/Exclusion        | <input type="checkbox"/> Violence-Intimate/Family<br>incl. Child Abuse/Neglect   |
| <input type="checkbox"/> Youth Mntl Health/Behaviors  | <input type="checkbox"/> Family Homelessness        | <input type="checkbox"/> Practice/Service Delivery to<br>underserved populations |
| <input type="checkbox"/> Health Disparities           | <input type="checkbox"/> Resilience & Coping        |  |
| <input type="checkbox"/> Systems Integrations/Design  | <input type="checkbox"/> Human Rights               |  |

Other: \_\_\_\_\_

<b>Category</b>	<b>Annual Dues</b>	
Regular Member	_____ \$150.00	Membership Certificate (optional) _____ \$ 7.00
Retired Member	_____ \$60.00	
Student Member (Proof of student status must be included)	_____ \$45.00	Additional contribution \$ _____ (Supports awards & special projects)
AACP Dual Membership	_____ \$240.00	
		<b>TOTAL ENCLOSED</b> \$ _____

Enclosed is my check in US dollars (no cash or foreign currency, please) made payable to:

**American Orthopsychiatric Association**

Charge my credit card       Mastercard       Visa

Name of Cardholder \_\_\_\_\_

Credit Card Number: \_\_\_\_\_ -- \_\_\_\_\_ -- \_\_\_\_\_      Expiration Date: \_\_\_\_\_ / \_\_\_\_\_