National Black Association for Speech-Language and Hearing

700 McKnight Park Drive, Suite 708 • Pittsburgh, PA 15237
Phone: 412-366-1177 • Fax: 412-366-8804 • email: nbaslh@nbaslh.org • www.nbaslh.org

NBASLH MEMBERSHIP APPLICATION

Name:_____

Credentials: _____

Mailing Address:_____

_____

City: _____State:_____ Zip:_____

Contact Information: work phone: _____

home phone: _____

fax number: _____

Email: _____

Current Employer: _____

POSITION/TITLE:
❒ Clinical Service Provider
❒ Clinical Supervisor
❒ Chair/Dept. Head/Manager
❒ Administrator/CEO/Partner
❒ Professor/Instructor
❒ Other (specify) _____

PRIMARY WORK SETTING:
❒ Public School
❒ Private School
❒ Hospital
❒ Other Health Care Facility
❒ Private Practice
❒ College/University
❒ Other (specify) _____

HIGHEST DEGREE EARNED:
❒ Bachelors
❒ Masters in SLP/AUD
❒ Doctorate in SLP/AUD

AREA OF PRACTICE:
❒ SLP
❒ AUD
❒ Ph.D. AUD
❒ EHI
❒ Other _____

CERTIFICATION/LICENSURE:
ASHA Certification? ❒ Yes ❒ No

State Licensure? ❒ Yes ❒ No

State(s)_____

Ethnicity *(optional)*: _____

May we refer potential clients to you? ❒ Yes ❒ No

MEMBER REFERRAL PROGRAM:
$5 NBASLH Bucks

Referring Member _____

STUDENTS

Graduate Students: To be eligible for student membership in NBASLH, you must be currently enrolled as a full-time student according to the full-time course load requirements at your institution.

Undergraduate Students: To be eligible for the student membership in NBASLH, you must be currently enrolled as a part-time or full-time student.

College/University: _____

Location:_____

Signature of advisor or department head:

_____

Classification:

❒ Undergraduate ❒ Master's ❒ Doctoral

Student Status: ❒ Full-time ❒ Part-time

AFFILIATES

❒ I am interested in joining an affiliate.
❒ I am interested in starting an affiliate.

METHOD OF PAYMENT

MEMBERSHIP TYPE:

❒ **Professional $75**

❒ **Associate $50**

❒ **Student.....$25**

TOTAL PAYMENT **$**_____

❒ Check/Money Order *(Make check payable to NBASLH)*
❒ Purchase Order # _____
❒ Visa or MasterCard *(Must complete the following information)*

CREDIT CARD ACCOUNT NUMBER

EXPIRATION DATE

SIGNATURE: X _____

DROP IT IN THE MAIL OR FAX IT TO 412-366-8804.

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