



EMDR International Association
5806 Mesa Drive, Suite 360
Austin, TX 78731-3785
(512) 451-5200 (Ph)
(512) 451-5256 (Fax)
info@emdria.org

INDIVIDUAL GROUP MEMBERSHIP APPLICATION

GROUP MEMBER REQUIREMENT

- Must be in a W2 relationship with the agency.
- Must fulfill additional member type requirements below.
- Application must be submitted through agency contact person or signed below:

AGENCY CONTACT: _____

I attest that the individual on this application is in a W2 relationship with our agency.

SIGNATURE: _____

GROUP - FULL MEMBER (\$100)

Additional Benefits: "Find a Therapist" online directory listing and voting privileges

- Must be licensed, certified, or the equivalent as a mental health professional or per the guidelines of your state, province or country.
- Must have completed EMDRIA Approved EMDR Training that included a minimum of 20 hours instruction, 20 hours practice, and 10 hours consultation.
- Must be able to provide a copy of current license and/or certificate of completion for an EMDRIA Approved EMDR Training to EMDRIA, if requested.

GROUP - ASSOCIATE MEMBER (\$100)

Associate Members are not listed in the Find a Therapist directory and do not have voting privileges.

- Must be licensed, certified, or the equivalent as a mental health professional or per the guidelines of your state, province or country **OR** pursuing licensure under supervision **OR** be in the process of completing EMDRIA Approved EMDR Training that includes a minimum of 20 hours instruction, 20 hours practice, and 10 hours consultation.

CONTACT / MAILING INFORMATION (REQUIRED FOR ALL / * = Required for Full Membership Only)

LAST NAME: _____ FIRST NAME: _____ MI: _____ Credentials: _____


Mailing Address: _____

City: _____ State:/Prov: _____ Zip: _____ Country: _____

Phone: _____ Mobile: _____ EMAIL: _____

License Type*: _____ License #*: _____ Jurisdiction (State)*: _____

Journal Preference: Online Only Both Online & Printed
Newsletter Preference: Online Only Both Online & Printed
May EMDRIA share your email with EMDRIA Training Providers to notify you about education programs? Yes No
Mailing Information above must be completed to receive printed materials. If not, preference will be changed to Online.



Go green with EMDRIA and select Online Only for your preferences!

FIND A THERAPIST DIRECTORY LISTING

Use the information as listed above List what is completed below No listing

Directory Address: _____

City: _____ State/Prov: _____ Zip: _____ Country: _____

Email: _____ Phone: _____ Website: _____

Add additional information (including a second address) to your member profile when you sign in online at www.emdria.org!

MEMBERSHIP LEVEL (all prices are USD)

CHOOSE ONE: FULL (must fill out Full Membership Verification Statements) -- OR -- ASSOCIATE

FULL MEMBERSHIP VERIFICATION STATEMENTS (REQUIRED):

- I am currently licensed as a mental health professional per the guidelines of my state, province or country.
- I completed an EMDRIA Approved EMDR Training (as stated on front) on _____ (date).

AGENCY NAME (REQUIRED): _____

I attest that I am currently in a W2 relationship with the agency listed above.

SIGNATURE: _____

I subscribe to EMDRIA's [Code of Conduct](#) and have read the [Statement on Diversity & Cultural Competence](#): Yes

PAYMENT (U.S. FUNDS ONLY) Use the blanks below to calculate your payment total. A \$10 tax-deductible donation to the EMDR Research Foundation has been automatically included in your registration. If you would like to opt-out of this donation, please check the box indicating such and do not add the \$10 to your total. If you would like to make an additional contribution to either the EMDR Research Foundation or to EMDRIA's Memorial Conference Scholarship Fund, please specify below:

MEMBERSHIP LEVEL COST (GROUP RATE)	\$100.00
EMDR Research Foundation Donation (<i>Tax-Deductible</i>).....	\$10.00 <input type="checkbox"/> Opt-Out
Additional EMDR Research Foundation Donation (<i>Tax-Deductible</i>).....	\$ _____
EMDRIA Memorial Conference Scholarship Fund Donation (<i>Not Tax-Deductible</i>).....	\$ _____
TOTAL PAYMENT	\$ _____

Credit Card (Visa/Mastercard/Discover Only) Check or Money Order Check #: _____

Card # _____ / _____ / _____ Expiration Date: _____

Name (as appears on card): _____ 3-Digit CCV Code: _____

Signature: _____ Billing Zip Code: _____