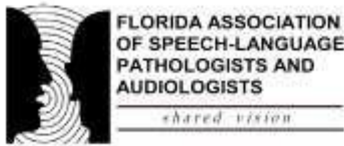


2017-2018
MEMBER APPLICATION FORM

❑ New Member ❑ Renewal

Mailing Information: ***(PLEASE PRINT ALL INFORMATION!!)***

Name: ____

Address: ____

City: ______________________________ State: _______ Zip: ________________

County: ________________________ Employer: ________________________

Home Phone: ____________________ ❑ Do not publish FAX Number: ____________________ ❑ Do not publish

Work Phone: ____________________ ❑ Do not publish E-mail: ________________________ ❑ Do not publish

❑ **DO NOT PUBLISH ANY INFORMATION ON THE MEMBERS WEBSITE SECTION**

How did you hear about FLASHA? ❑ **Colleague(s)** ❑ **Website**
❑**Facebook** ❑ **Convention/Workshop** ❑**Other**___________

Referral Information: Applicant was referred to be a FLASHA member by (A FLASHA Coupon will be sent to the current member who made the referral):

____

(Print Referral Name of the current FLASHA Member)

Check All Applicable Work Settings:

- ❑ University Employee
- ❑ University Faculty
- ❑ Skilled Nursing Facility
- ❑ Private School
- ❑ Pediatric Care
- ❑ Adult Care
- ❑ Clinic
- ❑ Hospital
- ❑ Private Office
- ❑ N/A (Student)
- ❑ Public School

Check All Applicable Specialty Fields:

- ❑ Speech-Language Pathology
- ❑ Audiology
- ❑ Deaf Education
- ❑ ________________

Memberships & Certifications:

Florida Licensure ❑ Yes ❑ No

If so: ❑ Speech-Language ❑ Audiology ❑ Dual

FL License #: ______________________________
ASHA #: ______________________________

ASHA CCC-SLP	❑ Yes	❑ No
ASHA CCC-A	❑ Yes	❑ No
ASHA CCC-SLP/A	❑ Yes	❑ No
DOE Certificate	❑ Yes	❑ No

Highest Degree Earned in Field:

University______________________________

Major: ______________________________

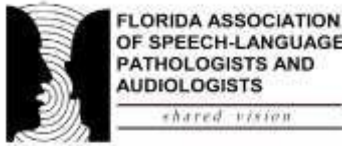
FLASHA Mission Statement

I certify that the information submitted above is correct. I understand that the mission of FLASHA is to serve the needs of audiologists and speech-language pathologists in the State of Florida by providing support, opportunities for professional growth, public awareness and advocacy of issues related to the highest quality care for the individuals we serve.

I also understand that in accepting membership in FLASHA, I certify that I have read, and agree to abide by, the Code of Ethics.

My signature below constitutes my consent to receive faxes, email and other communications from FLASHA or on behalf of FLASHA.

Signature: ______________________________ *Date:* ______________________



2017-2018
MEMBER APPLICATION FORM

❑ New Member ❑ Renewal

Name: ____

DUES ARE NON-REFUNDABLE

Dues are effective for one year (365 days) from the date of payment

For Working Professionals

❑ **Regular Member:** Holds Master's Degree or Higher.......$125.00

❑ **Clinical Fellow Member:** $50.00
(Available to Clinical Fellows during first year of clinical fellowship)

❑ **Associate Member:** Holds Bachelor's Degree $50.00

For Legacy Members

❑ **Retired Member:** $75.00
(Age 60-65, FLASHA member for 15 consecutive years, eligible to vote)

❑ **Sustaining Member:** $45.00
(Age 65 or older working part-time, or other allied professional)

For Student Members

❑ **Student Member** $25.00
(Must be enrolled full-time)

All applicants for student membership **must** submit the following information:

I certify that the above applicant is enrolled as a full-time student at (University Name) * ______________________________

with a projected month/year graduation date of * ______________

____

Signature - Dept. Faculty *Date*

***Required Information for Student Member application consideration**

Optional Contribution

FLASHA regularly conducts and/or sponsors special projects, legislative undertakings, and other activities that are not part of our regular budget. These special projects are essential to the long-term health, stability and growth of the association. FLASHA encourages every member to make an optional contribution to the FLASHA reserve funds so we may continue to offer these special projects.

I would like to provide an additional optional contribution to the FLASHA reserve funds: ❑ Yes ❑ No

❑ $5.00 ❑ $10.00 ❑ $25.00 ❑ $50.00 ❑ Other: _________________

Method of Payment

Discount Code (if available): ______________________________

❑ Check #_______for $_______enclosed (payable to **FLASHA**) ❑ VISA ❑ MC ❑ Amex

Card Number: ____ Exp. Date: ________ CVV Code: _____________

Name as Printed on Card: ____ Signature: ________________________________

Total Amount to Charge $: _________________

FLASHA now operates on a rolling dues year. This means that your paid membership dues will be good one year (365 days) from the date of payment. Dues payments may be deductible by members as an ordinary and necessary business expense. In accordance with Section 6033(e)(2)(A) of the Internal Revenue Code, as amended, members of the FLASHA are hereby notified that an estimated 15% of your FLASHA dues will be allocated to lobbying and political activities, and therefore is not deductible as a business expense.

NOTE THE NEW ADDRESS! MAIL YOUR COMPLETED APPLICATION AND PAYMENT TO:

FLASHA Headquarters • 8815 Conroy-Windermere Road, Suite 283 • Orlando, Florida 32835 • 407-749-6677