Arkansas Speech-Language-Hearing Association

P.O. Box 24103 Little Rock, Arkansas 72221
ph: 501.244.0621 fax: 501.224-0988

APPLICATION FOR MEMBERSHIP

First Name: _____ Middle: _____ Last Name: _____
Recruited/Referred by: _____

APPLYING FOR:

_____ Full member, Speech-Language Pathologist- -$60.00 SLP # _____
Requires a Master's degree or higher in Speech-language Pathology & adherence to the Code of Ethics adopted in 1991 *(if renewing after February 15, add $10)*

_____ Full member, Audiologist - $60.00 AUD # _____
Requires a Master's degree or higher in Audiology & adherence to the Code of Ethics adopted in 1991 *(if renewing after February 15, add $10)*

_____ Associate member-$45.00
Requires an undergraduate degree in speech or hearing or an allied Profession. Must abide by the spirit of the Code of Ethics *(if renewing after February 15, add $10)*

_____ Student member - $25.00
Requires full-time enrollment in speech-language pathology or audiology

Former Student Members will receive a $10.00 discount on initial Full member dues provided they have current student membership status when they apply.

Home Address_____ City _____State _____ Zip _____

Home Phone _____ Email Address _____

Place of Employment_____

Address_____ City _____State _____ Zip _____

County _____ Work Phone _____ Fax _____

Full & Associate Members: Academic Degree _____ Year _____ Institution _____
CERTIFICATION/LICENSURE (check all that apply)

_____ASHA CCC-SLP _____ASHA CCC-A _____ASHA CF-SLP

_____AR Licensure, SLP _____AR Licensure, A _____Public School Certification/Licensure

Student Members:

A. I am currently a full-time undergraduate/graduate (circle one) student at: _____
(name of university)

B. Estimated date of graduation: _____
C. Signature of Program Chair or Advisor: _____

** Membership dues are not deductible as charitable contributions for federal income tax purposes. In addition 21 % of your dues spent for governmental relations are not deductible as a business expense.*

SEND APPLICATION & DUES TO:
ArkSHA
P.O. Box 24103
Little Rock, AR 72221

FAX: 501-224-0988

Check #: _____
Visa/ MasterCard #: _____-_____-_____-_____
Exp. Date: _____ CVV: _____
Name on Card: _____
Billing Address (if diff from above):
_____