

Membership Application

In the form below please enter the address information that you would like us to use to send you MMHCA mailings, including phone and e-mail address.

Full Name _____
 PhD MA LPC LLPC NCC CCMHC CAC LMFT LCSW
 Other _____ Other _____ Other _____

Business Name _____
Address _____
City _____ State _____ Zip _____
Work Phone _____ Fax _____ Home Phone _____
E-mail _____ County _____

If you would like us to post your information on our MMHCA web site please fill out the form below. Where the information is the same as in the above form, please indicate such. In addition please enter your counseling specialties and age groups you work with.

I would like the information below posted on the MMHCA web site www.mmhca.org

Business Name _____
Address _____
City _____ State _____ Zip _____
Work Phone _____ Fax _____
E-mail _____ County _____
Specialties _____

Age Groups _____

Membership Dues

- MMHCA Clinical - \$75 MMHCA Regular - \$75
 MMHCA Student - \$55 MMHCA Associate - \$75

Professor's signature and phone #

- *MMHCA/AMHCA Dual Membership \$191
(AMHCA \$131 plus MMHCA \$60 unified dues provides 20% savings on both MMHCA and AMHCA membership dues)
 Addition contribution \$ _____
 Total Enclosed \$ _____
Check _____ Charge _____ (See below)

Please charge my VISA/MC

Card #: _____ Exp. Date: _____

Signature: _____

For MMHCA only membership, send to: MMHCA, P.O. Box 80036, Rochester, MI 48308

* For MMHCA/AMHCA dual membership, please send your application and payment to:
AMHCA c/o Wachovia Bank, P.O. Box 758717, Baltimore, MD 21275