# APPLICATION FOR AFFILIATION AS A NHCLA MEMBER
# ATTORNEY MEMBER

**Before completing application please see NHCLA Minimum Standards located at www.collaborativelawnh.com**

## SECTION 1: CONTACT INFORMATION

NAME: _____

FIRM NAME (if applicable): _____

ADDRESS: _____

PHONE: _____ EMAIL: _____

WEBSITE: _____

## SECTION 2: ATTORNEY MEMBER APPLICATION

Attorney Member requirements:

- Member in good standing in a state bar association;
- Support for the principles of Collaborative Practice;
- Completion of a minimum level of training in Collaborative Practice (12 hours of Interdisciplinary Collaborative training);
- A history for maintaining high ethical standards;
- Intent to be available to provide Collaborative Practice services;
- Payment of annual dues;
- Compliance with continuing education standards.

*If you don't meet membership requirements please consider joining as a "Supporter"*

**Information about your professional accreditation:**
Please list the following:

1. The states where you are licensed to practice law;
2. Date of each bar admission; and
3. Bar identification numbers, if applicable.

_____
_____

Briefly describe your background experience in the practice of law including information as to your areas of practice:

_____
_____
_____

**Information about your collaborative training:**
Date, location and sponsoring organization of your training in Collaborative dispute resolution:

_____
If this training was not sponsored by NHCLA please attach a copy of your certificate of attendance.

**Disciplinary history: initial below**

Has any disciplinary action been taken against you within the past 5 years by a professional regulatory or certifying organization in any jurisdiction? _____yes _____ no. If yes, please explain in detail including the date, jurisdiction and name of governing body.

**Please initial below that you will abide by the following general requirements for Collaborative Professionals:**

_____ I agree to be a member in good standing of NHCLA, and to comply with the Minimum Standards;
_____ I accept the IACP Mission Statement; and
_____ I will strive to practice in a manner consistent with the IACP Principles of Collaborative Practice and the IACP Ethical Standards for Collaborative practitioners.

I certify that the information contained herein is true and accurate.

Date: _____ Signature: _____

Please mail your application to: CLANH, PO Box 803, Londonderry NH 03053.

Thank you!