APPLICATION FOR AFFILIATION AS A NHCLA MEMBER
MENTAL HEALTH PROFESSIONAL

Before completing application please see NHCLA minimum standards at www.collaborativelawnh.com

SECTION 1: CONTACT INFORMATION

NAME: _____

ADDRESS: _____

PHONE: _____ EMAIL: _____

WEBSITE: _____

SECTION 2: MEMBER APPLICATION

Member requirements:

- Professional license in State of NH or equivalent in adjoining state;
- 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:

Mental Health professionals must hold one of the following designations (circle all that apply):

Ph.D Psy.D LICSW MFT LPP LCMHC

State:_____ License #_____

Other Certification(s): _____

Briefly describe your background experience in the field of Mental Health particularly as it relates to Family Systems and/or families experiencing divorce:

_____
_____
_____

Information about your 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? _____No _____Yes

If yes, please explain_____

_____

_____

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 minimum standards;

_____I accept the IACP Mission Statement;

_____I will strive to practice in a manner consistent with the IACP Principles of Collaborative Practice and the IACP Ethical Standard 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!