

**California Mental Health Counselors Association  
Membership Form**

**COMPLETE & mail to  
address below**

\_\_\_\_ NEW \_\_\_\_ RENEWAL

NAME \_\_\_\_\_  
Last First Middle Initial

HOME ADDRESS \_\_\_\_\_ CITY, ST ZIP \_\_\_\_\_

HOME PHONE (\_\_\_\_) \_\_\_\_\_ FAX (\_\_\_\_) \_\_\_\_\_

WORK ADDRESS \_\_\_\_\_ CITY, ST ZIP \_\_\_\_\_

WORK PHONE (\_\_\_\_) \_\_\_\_\_ FAX (\_\_\_\_) \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_ DEGREE \_\_\_\_\_

Licensure/Certifications \_\_\_\_\_

WORK SETTING: Public Agency \_\_\_\_ Hospital \_\_\_\_ University \_\_\_\_ School \_\_\_\_

Private Non-Profit \_\_\_\_ Private Practice \_\_\_\_ Other \_\_\_\_\_

*Indicate below if you are interested in contributing to CAMHCA in the following areas:*

Licensure \_\_\_\_ Public Relations \_\_\_\_ Professional Development \_\_\_\_ Membership \_\_\_\_

Legislative \_\_\_\_ Ethics \_\_\_\_ Newsletter \_\_\_\_ Training \_\_\_\_ Other \_\_\_\_\_

**ANNUAL MEMBERSHIP DUES:** \*For unified dues, please go to [www.amhca.org/join](http://www.amhca.org/join)

\_\_\_\_ **Professional Membership, \$100**

Professional Mental Health Counselor with Masters degree or higher in Counseling or related field.

\_\_\_\_ **Student, \$25 (School: \_\_\_\_\_)**

Graduate student in Counseling or related field from accredited school. Non-Voting Membership.

\_\_\_\_ **Para-professional or Supporter, \$25**

Currently employed in mental health service delivery or interested supporter of mental health counseling. Non-Voting Membership.

\_\_\_\_ **Voluntary Donation**

Voluntary donation to the California Coalition for Counselor Licensure (NOT tax deductible).

**Make checks payable to CAMHCA and mail to: CAMHCA, PO Box 1594, San Andreas, CA 95249**