FLORIDA ASSOCIATION OF SPEECH-LANGUAGE PATHOLOGISTS AND AUDIOLOGISTS
shared vision

MEMBER APPLICATION FORM

❑ **New Member** ❑ **Renewal**

Mailing Information: ***(PLEASE PRINT ALL INFORMATION!!)***

Name _____

Address _____

City _____ State _____ Zip _____

County _____

Employer _____

Home Phone_____ ❑ Do not publish

Work Phone_____ ❑ Do not publish

FAX Number_____ ❑ Do not publish

E-mail _____ ❑ Do not publish

Secondary E-mail _____ ❑ Do not publish

❑ **DO NOT PUBLISH ANY INFORMATION ON THE MEMBERS WEBSITE SECTION**

How did you hear about FLASHA? ❒ Colleague(s) ❒ Website

❒Facebook ❒ Convention/Workshop ❒Other_____

Referral Information: Applicant was referred to be a FLASHA member by (A FLASHA Coupon will be sent to the current member who made the referral):

_____

(Print Referral Name of the current FLASHA Member)

Check All Applicable Work Settings:

❑ University Employee
❑ University Faculty
❑ Skilled Nursing Facility
❑ Private School
❑ Public School
❑ Pediatric Care
❑ School District:_____
❑ Clinic
❑ Hospital
❑ Private Office
❑ N/A (Student)
❑ Adult Care
❑ _____

Check All Applicable Specialty Fields:

❑ Speech-Language Pathology
❑ Audiology
❑ Deaf Education
❑ _____

Memberships & Certifications:

Florida Licensure ❑ Yes ❑ No

If so: ❑ Speech-Language ❑ Audiology ❑ Dual

FL License #_____ ASHA # _____

ASHA CCC-SLP ❑ Yes ❑ No

ASHA CCC-A ❑ Yes ❑ No

ASHA CCC-SLP/A ❑ Yes ❑ No

DOE Certificate ❑ Yes ❑ No

Highest Degree Earned in Field:

University _____

Major: _____

Degree _____ Date _____

List any language, other than English, that you speak fluently:

_____

Revised 02/2017

FLASHA Mission Statement

I certify that the information submitted above is correct. I understand that the mission of FLASHA is to serve the needs of audiologists and speech-language pathologists in the State of Florida by providing support, opportunities for professional growth, public awareness and advocacy of issues related to the highest quality care for the individuals we serve.

I also understand that in accepting membership in FLASHA, I certify that I have read, and agree to abide by, the Code of Ethics.

My signature below constitutes my consent to receive faxes, email and other communications from FLASHA or on behalf of FLASHA.

Signature _____

Date _____

MEMBERSHIP CATEGORY

DUES ARE NON-REFUNDABLE

Dues are effective June 1 through May 31 each year

❑ **Regular Member:** Holds Master's Degree or Higher.....$125.00

❑ **Clinical Fellow Member:** $50.00
(Available to Clinical Fellows during first year of clinical fellowship)

❑ **Retired Member:** $75.00
(Age 60-65, FLASHA member for 15 consecutive years, eligible to vote)

❑ **Associate Member:** Holds Bachelor's Degree $50.00

❑ **Sustaining Member:** Allied Profession or part-time age 65+...$45.00
(May not vote, hold office or be eligible for Life Membership)

❑ **Student Member** (Must be enrolled full-time).....$25.00

All applicants for student membership **must** submit the following information:

I certify that the above applicant is enrolled as a full-time student at (University Name) *_____ with a projected month/year graduation date of *_____/_____

_____* _____

Signature - Dept. Faculty *Date*

***Required Information for Student Member application consideration**

Method of Payment

❑ Check #_____ for $_____ enclosed (payable to **FLASHA**)

Credit card: ❑ VISA ❑ MC ❑ Amex

Card Number _____

Exp. Date _____ CVV Code _____

Name as Printed on Card _____

Signature _____

Billing Address _____

Total Amount to Charge $ _____

**Payment Plan Available for Regular Members (contact HQ)*

The dues year is June 1 to May 31. Dues payments may be deductible by members as an ordinary and necessary business expense. In accordance with Section 6033(e)(2)(A) of the Internal Revenue Code, as amended, members of the FLASHA are hereby notified that an estimated 15% of your FLASHA dues will be allocated to lobbying and political activities, and therefore is not deductible as a business expense.

Mail completed application with your payment to:
FLASHA • 222 S. Westmonte Drive, #101
Altamonte Springs, FL 32714
With VISA, MC or Amex: FAX 407-774-6440
Sign up online at: www.flasha.org for the FLASHA Email Alerts