RIMHCA Membership Form	Contact us:
www.rimhca.org	P.O. Box 113945, North Providence, RI 02911 email: rimhca@gmail.com

Member Information:

Name_____EmailAddress_____

Mailing Address_____

Phone: Home_____ Cel_____

Select	Membership Type	Yearly Fee
	Join RIMHCA – Licensed Mental Health Counselor with an active license. License #_____ Expiration date_____ Mail application and check or money order for RIMHCA to: RIMHCA, P.O. Box 113945, North Providence, RI 02911	$65
	Join RIMHCA with AMHCA/RIMHCA Unified Dues Submit application online at www.amhca.org . AMHCA notifies RIMHCA of your membership status. No need to submit this form.	$187 Save $47 by combining national & state professional association membership
	Behavioral Healthcare Professional with an active license or certificate (e.g. LICSW, LMFT, LCDP, CCDP)	$65
	Student current enrolled in a graduate program related to counseling College/University _____Graduate degree prg._____	$28
	Retired from the counseling profession	$28

In addition, if you would like to be included in RIMHCA Find a Counselor web page, please enter your information here: **http://tinyurl.com/rimhca-directory-questionnaire**

I verify that the information I have provided is accurate to the best of my knowledge. By submitting my application, I agree to continue to adhere to the Code of Ethics of my profession (e.g. ACA, AMHCA, NBCC) and will report any professional disciplinary matters within 60 days of occurrence.

Submit your information with payment to the contact information above.

Member's Signature:_____ Date:_____