



**Illinois Society for Clinical Social Work**  
 PO Box 2929, Chicago, IL 60690-2929  
 (312) 346-6991 office (708) 995-5454 fax  
 ISCSW@ilclinicalsw.com www.ilclinicalsw.com

**Membership Dues Form 2009**

**Please check membership category and return application with payment (checks payable to ISCSW).**

Fellow Member (MSW and 5+ years employment) (This membership category recognizes the senior status of our members; inherent in senior status is a slightly greater contribution of dues.)	\$200	_____
General Member Full Year	\$135	_____
First Time General Member (MSW and 3+ years employment)	\$135	_____
(Additional Family Member – General)	\$75	_____
(Additional Family Member - Fellow)	\$110	_____
Affiliate Member (Allied Field)	\$135	_____
Associate Member (New Professional) (Fewer than 3 years employment beyond MSW)	\$60	_____
Emeritus Member (Retired Social Worker)	\$50	_____
Student Member	\$50	_____
	<b>TOTAL</b>	_____

Yes, I give permission to include information on the website member directory. List any other information you may wish to be added to the website. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

***Consider becoming active in the Society by participating in one of the following committees:***

- |   |   |
|---|---|
| <input type="checkbox"/> Education – Sunday Seminars      | <input type="checkbox"/> Public Relations           |
| <input type="checkbox"/> Education – Spring Conference    | <input type="checkbox"/> Membership                 |
| <input type="checkbox"/> Cultural Competency Committee    | <input type="checkbox"/> Newsletter                 |
| <input type="checkbox"/> Professional Standards & Inquiry | <input type="checkbox"/> Special Events/Information |
| <input type="checkbox"/> Legislation                      | <input type="checkbox"/> New Professionals          |

I agree to abide by the Code of Ethics, By-Laws, and Adjudication Procedures of the Illinois Society for Clinical Social Work.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed name: \_\_\_\_\_ Email Address: \_\_\_\_\_

Work Address: \_\_\_\_\_ Phone (O) \_\_\_\_\_

Private Practice: \_\_\_\_\_ Phone (PP) \_\_\_\_\_

Home Address: \_\_\_\_\_ Phone (H) \_\_\_\_\_

PREFERRED MAILING:  Work  Private Practice  Home [\*Make all checks payable to the Illinois Society for Clinical Social Work]