ISEPP MEMBERSHIP FORM

ISEPP is a nonprofit 501(3)(c). We are a volunteer organization with no officers receiving salaries or other financial benefits.

Name ______________________________________________________________
Address ___________________________________________________________
City __________________________
State _______ Zip _________ Country _________________________________
E-mail _________________________ Phone __________________________

Dues (in US Dollars) - Check one:
_____ $100 for US address _____ $110 for international address _____ $70 for students

If you are experiencing a financial hardship and a requesting a reduced membership fee, please contact Chuck Ruby, Ph.D., docruby@me.com; 301-646-6022, to explain the details of your request.

Payment Information: I am also enclosing a tax-deductible donation of $ __________.

_____ Check (please enclose check)
_____ Credit Card Card Number __________________________________________
Expiration Date: _______ CSC (code on back of card) _______
Billing Zip Code __________
Signature:________________________

Psychotherapy Referral Source: If you are a licensed clinician who subscribes to the ISEPP philosophy (see our Mission Statement on the ISEPP website at www.psychintegrity.org) and are interested in receiving referrals, please check here ____ and indicate the state in which you are licensed ______.

Complete this form in its entirety and mail, along with your check or credit card information to:
ISEPP, 100 Bradford Heights Rd., Syracuse, NY 13224.