DSHA Membership Application

Type of Membership Requested:
☐ Full ☐ Associate ☐ Student

Name: _____

Address: (Check preferred mailing address)
☐ Home: _____

_____

☐ Work: _____

_____

Telephone:
Home: ( ) _____

Work: ( ) _____

E-mail: _____

Professional title: _____

Highest degree: _____
University granting highest degree:
_____

Specialization: ☐ SLP ☐ Aud ☐ Other

ASHA Member: ☐ Yes ☐ No

CCC: ☐ Yes ☐ No

Private Practice: ☐ Yes ☐ No

☐ I do <u>not</u> wish to be included in the DSHA Directory.

Delaware State License: ☐ Yes ☐ No
Other State Licenses: _____

Application date: _____
Please enclose check for $35.00 made out to "DSHA".

Delaware

Speech-Language-Hearing

Association

www.dsha.org