IAPSP MEMBER REGISTRATION

Please use one form per registration.

Last Name: First Name: Degree(s):

Address:

City: State: ZIP/ Postal Code: Country:

Phone Number: ( ) E-Mail:

Profession (please check): Social Worker: _____ Psychologist: _____ Physician: _____ Other: _____

MEMBER FEES:

Please choose from the options below for your fee:

Region 1: USA		✓
Professional	**$210**	
Reduced: Candidate* / Reduced Professional*	**$125**	
Student **	**$50**	

Region 2: Australia/Canada/Europe/Israel/Japan/New Zealand		✓
Professional	**$170**	
Reduced: Candidate* / Reduced Professional*	**$100**	
Student **	**$40**	

Region 3: Argentina/Iran/South Africa/Turkey		✓
Professional	**$85**	
Reduced: Candidate* / Reduced Professional*	**$50**	
Student **	**$20**	

Region 4: All other countries not listed above		✓
Professional	**$125**	
Reduced: Candidate* / Reduced Professional*	**$75**	
Student **	**$30**	

PROFESSIONAL is our Standard Membership.

* REDUCED RATE is for candidates, academics and others with no or very small practices, and others for whom the standard rate would preclude membership. IAPSP is pleased to offer reduced rates only to those for whom the standard rate would preclude them from membership.

** STUDENT RATE: – Includes interns and post-docs.

IAPSP JOURNAL DELIVERY:

A subscription to the IAPSP Journal: Psychoanalysis, Self & Context (PSC) is included in all memberships. You can choose to receive the journal via online access only and your membership fee will be reduced by 10%. If you choose to receive the paper copy, online access is also available. Please make your selection below:

I would like to receive the journal PSC via:
{ } Online only

{ } Online and print delivery
(for print delivery please ensure that your mailing address is complete above.

Do you belong to a Member Institute of IAPSP?

If so, which one?: _____
(this allows a further 10% discount off of the membership fee)

PAYMENT INFORMATION

*Payment must accompany registration form. Fees in **U.S. dollars**.*

TOTAL AMOUNT DUE **$_____**

☐ Check Enclosed. Payable to: **IAPSP**
(A $25.00 U.S. fee will be assessed for returned checks)

☐ Credit Card: ☐ VISA ☐ MasterCard ☐ AMEX

Card #:

Exp. Date: 3- or 4-Digit Security Code#:

Signature:

Credit Card Billing Statement Address:

IF PAYING BY CHECK, SEND TO:

IAPSP 10685-B Hazelhurst Dr. #26072 Houston, TX 77043 USA
(WE CAN ONLY ACCEPT CHECKS FROM THE UNITED STATES IN USD.)