Arkansas Speech-Language-Hearing Association
2010 Membership Renewal / Directory Information Form

PLEASE PRINT NEATLY

Please mail with a check payable to ArkSHA to:
ArkSHA, P.O. Box 250261, Little Rock, AR 72225 (501) 244-0621

_____ **$50 for FULL Membership (***Master's Degree or Higher***)** ☐ **SLP** ☐ **AUD**

_____ **$45 for ASSOCIATE Membership (***Undergraduate Degree or Allied Profession***)**

_____ **$25 for STUDENT Membership** *(Full-time Enrollment in Speech Language Pathology or Audiology)*
(Estimated Date of Graduation _____)

If renewing after February 15, 2010, please include a $10.00 late fee.

Legal Last Name: _____ First Name: _____ Middle Name/Initial: _____

Prior/Maiden Name if previously used for ArkSHA membership: _____

Arkansas License Number(s): SLP# _____ A# _____ Public School Cert./ ☐ Lic.: _____

Degree: _____ Certification: _____ Graduated From:_____

Work Setting: ☐ School ☐ University ☐ Rehabilitation ☐ Clinic ☐ Hospital ☐ Other

Employment Information

Employer: _____
Company/School - Department

Business Address: (Physical or P.O. Box - Not Both) _____

Business City: _____ Business State: ____ Business Zip (+4 Required): _____- _____

Business Phone: ( ) _____ Business Fax: ( ) _____

Home or Mailing Address for mailed ArkSHA materials (since you may change employers)

☐ Same as Business Contact Information

Mailing Address: (Physical or P.O. Box - Not Both) _____

Mailing City: _____ Mailing State: _____ Mailing Zip (+4 Required): _____-_____

Phone: ( ) _____

EMAIL ADDRESS: _____

I have enclosed an additional $ _____ for the Scholarship Fund.

☐ In Memory ☐ In Honor of: _____

TO PAY BY CREDIT CARD. You may fax this form with the following information to (501) 244-2333

Type (VISA or MasterCard Only): _____VISA _____ MasterCard Name on Card_____

Credit Card Number:_____ Expiration Date: _____

Billing Address: _____Signature: _____