

Theraplay Association Membership and On-Line Referral Resource Directory

THE
THERAPLAY[®]
INSTITUTE



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Please print.

Fax or mail to **The Theraplay Institute**

Make checks payable to:
The Theraplay Institute

Membership Types	Fee	Benefits
Clinician	\$50/yr	<ul style="list-style-type: none"> • 50% discount on Directory listing • \$25 discount on training • 10% discount on Theraplay Institute media purchases • Special offers on media purchases • 2 newsletters per year • Theraplay thank-you gift for renewing members • Theraplay tote-bag for new members
Full-time Student	\$30/yr	Same as above (proof of status required)
Parent/Lay Advocate	\$30/yr	Same as above
Agency	\$200/yr	Same as above PLUS <ul style="list-style-type: none"> • 4 copies of each newsletter • 4 Theraplay thank-you gifts for renewing members • 4 Theraplay tote-bags for new members

Directory Listing Types	Fee	Benefits
Individual Clinician	\$100/yr	<ul style="list-style-type: none"> • Professional/contact information listed by city & state on the Theraplay website at www.theraplay.org • Automatic membership to The Theraplay Association
Agency Listing (3+ staff with Theraplay training)	\$400/yr	<ul style="list-style-type: none"> • Agency/contact information listed by city & state on the Theraplay website at www.theraplay.org • Automatic membership to The Theraplay Association

Yes, I wish to join the Theraplay Association Type: ___Clinician ___Student ___Parent/Advocate ___Agency

Yes, I wish to be listed on your on-line directory Type: ___Individual Clinician ___Agency

Name: _____ Degrees/Licenses: _____

Job Title: _____

Name of Agency or Practice: _____

Mailing Address: _____

Directory Listing Address: _____

Work/Directory Listing Phone: _____ Home Phone: _____

Fax: _____ E-mail: _____

If agency directory listing, Names of staff members: _____

Area of specialty (15-word limit, please): _____

Website: _____

Please indicate what Theraplay coursework you have completed (if agency listing, indicate what your staff has attended):

Intro Theraplay & MIM Intro Group Theraplay Advanced Theraplay
 Intermediate Theraplay & MIM Intermediate Group Certified Theraplay Therapist

With my signature and enclosed payment of \$_____, I wish to join the Theraplay Association and/or be included in the On-Line Referral Resource directory on The Theraplay Institute's website at www.theraplay.org.

Signature: _____ Date: _____

Payment Method: Check is enclosed. ___ or: Visa/MC # _____ Exp. Date _____

Name on account _____ Signature _____

Thank you for joining and welcome to the Theraplay community!