ASIAN INDIAN CAUCUS MEMBERSHIP FORM

Name: _____
(Last) (First)

Type of Membership: ___ Professional ___ Student
(Membership Cost: Professional $ 20 Student $ 10)

Mailing Address _____
Street

_____
City State Zip

Phone: _____ _____
(Work) (Home)

Email: _____

Professional Title: _____

Employment Setting: ___School ___ University ___ Hospital
___ Rehab/Agency ___ Private Practice

ASHA Member: Yes/ No NSSLHA Member: Yes/No

ASHA Certification: ___CCC-SLP ____CCC- A _____None

If certified do you consent to be listed as a service provider for individuals with Asian Indian origin in your geographical area? Yes/No

If yes, list your area(s) of clinical expertise

Languages you speak:
Proficient/can provide services in: _____

Can translate or share information in:_____

_____
(Signature)

Please include your dues (Professional: $ 20 Student: $ 10) along with this form and mail it to:

Deepa J. Aier, Ph.D., CCC-SLP
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Phoenix, AZ 85008
deepa.aier@gmail.com