



Application for Membership or Affiliation

Please read all the enclosed information prior to filling out the application.

*** Required information**

* **Title** (check one) Dr. Mr. Mrs. Ms. Other (please specify) _____

* **Name** _____
(Surname) (First) (Middle)

* **Date of Birth** ____/____/____ **Sex** Male Female
(Day) (Month) (Year)

Home Address _____
(Number) (Street) (Suite)

(City) (Province) (Postal Code)

(Telephone) (Fax)

* **Facility/Company** (where employed) _____

* **Position** _____

Office/University Address(if student) _____
(Number) (Street) (Suite)

(City) (Province) (Postal Code)

(Telephone) (Fax)

* **At which address do you wish to receive mail** Home Office University

* **At which address do you wish to be listed in the OPA Web** Home Office University

E-mail Address _____

* **If you have e-mail, do you wish to be added to the OPA membership listserv**

Yes No Already on listserv

* **Highest Academic Degree** _____
(Degree) (Granting Institution) (Year)

* **Membership Category** (please see attached) _____

***If you are an Early Career Psychologist (ECP), do you wish to be added to the ECP listserv** Yes No

* **Name of Supervising Psychologist/Psychological Associate** _____
(if unregulated and applying under Professional Affiliate Category)

Section Memberships (please insert appropriate no. (nos.)) _____

Were you recruited by a current OPA member? Yes No

Name of person who recruited you _____

The following does not apply to Students Affiliates (continue to "For Student Affiliation Only")

* **Regional Representation** (please see attached) _____

* **Area of Practice** (please see attached) Primary _____ Secondary (if applicable) _____

* **College of Psychologists of Ontario Registration** Yes No

* **Supervised Practice** **Autonomous Practice**

* **College Registration Number:** _____

Other Jurisdictions (states/provinces) in which you are authorized to practice
(indicate title, number, and date of Certification)

Languages in which Services are Offered English French Other _____

Independent Practice Full-Time Part-Time None

Canadian Register of Health Service Providers in Psychology Listee Yes No

Do you want information on the referral service? Yes No

* **Are you willing to supervise candidates preparing for Registration?** Yes No

* **Are you willing to be a Student Mentor?** Yes No

