Evergreen Behavioral Health Association (EBHA)
Independent Practice Association (IPA)

ASSOCIATE Individual Membership Application for Professionals Working Towards Licensure

This application is for applicants who are not yet independently licensed in the State of Oregon, but who are under the supervision of a qualified, fully-licensed mental health practitioner
who is a member of EBHA or who is in the process of applying for EBHA membership.
There is a separate Membership Application for *Licensed Professionals*.

Please complete all fields to ensure timely processing of your application. All information will be kept confidential, except for your practice information in the box below. This information will be posted on the EBHA website.

Name: Date of Birth:
NPI # (if applicable):
Oregon license type *you are working towards*:
☐CADC ☐LCSW ☐LPC ☐LMFT ☐PHYSICIAN ☐PMHNP ☐PSYCHOLOGIST ☐OTHER:

Liability insurance company (required):
Policy #: Policy Holder: Expiration Date:

YOUR SUPERVISOR:

*Your supervisor has to be an EBHA member or be in the process of applying for EBHA membership

Name:
Oregon license(s) type:
☐CADC ☐LCSW ☐LPC ☐LMFT ☐PHYSICIAN ☐PMHNP ☐PSYCHOLOGIST ☐OTHER:

PRACTICE:

*If you have more than one practice location, please either complete a separate application for each practice, or indicate information about your other practice in the Comments section on the last page.

Type of practice: ☐Sole Proprietorship ☐Group Practice ☐Corporation ☐Other (Pls explain in Comments section on pg2)
Years in this practice:
Group or Corporation name (if applicable):
How is insurance billed in this practice? ☐Only electronically ☐Only on paper ☐Both electronically & on paper ☐Do not bill insurance

The practice information in this box will be listed on the EBHA website unless you indicate otherwise.

Practice Address:
City: State: Zip: ☐Do not list on EBHA website
Office Phone: ☐Do not list on EBHA website
Fax: ☐Do not list on EBHA website
Cell Phone: ☐Do not list on EBHA website
Email Address: ☐Do not list on EBHA website
Website: ☐Do not list on EBHA website

Billing Address (*if different from Practice Address*):

City: State: Zip:

Billing contact person:

Phone: Fax:

Email Address:

MEMBERSHIP

Membership Type: Associate Individual Membership

*There is a separate application for *Licensed Professionals*.

MEMBERSHIP FEE PAYMENT

EBHA Membership Fee per calendar year: $100.00. Make check payable to *EBHA IPA*.

Mail check and application to: *EBHA IPA*, PO Box 2538, Corvallis, OR 97330

ATTESTATION:

I hereby agree that I will abide by the Code of Ethics of my professional licensing board, and agree to review by the Evergreen Behavioral Health Association (EBHA) Quality Assurance Committee, in accordance with the EBHA bylaws. I further agree to notify EBHA if I am ever not in good standing with my licensing board or if I am incapacitated or decide to cease providing independent services. I further understand that falsification of information, conviction of a felony, reprimand by a licensing board, or revocation of licensure may be grounds for rejection or termination of the EBHA membership and of any and all benefits resulting therefrom. I understand that my application for membership will be presented to the EBHA Board of Directors for final approval. I will receive notice of the Board's decision within 60 days of submission, or notification of why this timeline is not met.

Signature:_____ Date: _____

If completing this electronically, print the completed form and sign the printed copy

Feel free to write any additional comments with regards to this application:

Thank you for your interest in partnering with EBHA toward the goal of improving the quality of Behavioral Healthcare in Oregon and the quality of our lives as Behavioral Healthcare Providers.