Evergreen Behavioral Health Association (EBHA)

Membership Application for Licensed Professionals and Registered Interns

Please complete all fields to ensure timely processing of your application. All information will be kept confidential, except for your practice information. Depending on your permission, this information may be posted on the EBHA website.

Name: _____ **Date of Birth**: _____

NPI #: _____

☐ CADC ☐ LCSW ☐ LMFT /MFCC ☐ LPC ☐ PHYSICIAN ☐ PMHNP ☐ PSYCHOLOGIST ☐ REGISTERED INTERN ☐ OTHER: _____

Oregon license number: _____ **License expiration date**: _____

Liability insurance company: _____

WORK SETTING:

If you have more than one practice location, please indicate information about your other practice location in the Comments section on the last page.

Sole Proprietorship (name): _____

Group Practice (name): _____

Employed by corporation (name): _____

Agency (name): _____

If you are a Registered Intern:

Supervisor's name: _____

Supervisor's LIcense #: _____

Practice/ Employer 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**

MEMBERSHIP FEE PAYMENT

EBHA Membership Fee per calendar year is $20. Fee may be paid through the payment link on the Membership page of www.ebhaipa.org. Alternatively, mail check made out to EBHA: EBHA IPA, PO Box 2538, Corvallis, OR 97330. To submit this application, email as an attachment to: info@ebhaipa.org

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 behavioral health 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:

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

Thank you for partnering with EBHA to improve the quality of behavioral healthcare in Oregon, and to improve the quality of our lives as behavioral healthcare providers.

TO SUBMIT THIS APPLICATION, DOWNLOAD AND EMAIL AS AN ATTACHMENT TO: INFO@EBHAIPA.ORG