Evergreen Behavioral Health Association (EBHA)

Membership Application for Licensed Professionals and Registered Interns/Associates

Applications and payment will be reviewed at EBHA's monthly board meeting. You will be notified of your membership status by email after that. If you need membership status information sooner, please contact ebha.secretary@gmail.com. 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 # _____

Home Address _____

☐ CADC ☐ LCSW ☐ LMFT /MFCC ☐ LPC ☐ PHYSICIAN ☐ PMHNP ☐ PSYCHOLOGIST ☐ REGISTERED ASSOCIATE

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 or Associate:

Supervisor's name: _____

Supervisor's LIcense #: _____

Would you like to be added to the EBHA members only google group?

Yes ☐ No ☐

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 $25, payable at time of application.

To pay on-line, go to link at top of ebhaipa.org home page.

☐ Mark this box to write a check and mail it to: EBHA IPA, PO Box 2538, Corvallis, OR 97339.

To submit this application, email as an attachment to: ebha.secretary@gmail.com

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 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:

Please let us know what interests you about joining EBHA, and which areas you might wish to get involved with (educational programming, membership outreach, community collaborations, board of directors, social events, website and technology, diversity-equity-inclusion)

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: EBHA.Secretary@gmail.com